OCD CLINICS
New Braunfels – Carrollton – The Woodlands

CLIENT INFORMATION

Initial Appointment Date: ____/____/_____

First Name: ____________________ Initial:____ Last Name:____________________________

Date of Birth:___________________________ Social Security No.:_______________________

Sex: _____ Marital Status: ________ How did you hear about us: _______________________

Address:____________________________________ City:_________________ Zip: __________

Employer or School:______________________________________ Full Time___ Part Time___

Circle The Preferred Phone Number: Home (____)____________ Work (____)_____________

Cell Phone: (____)____________ Email: *Please note email is not considered secure communication:*

________________________ Religion:______________

NAME AND ADDRESS OF PHYSICIAN:____

____

PAYMENT INFORMATION (we will need a copy of credit card and photo ID)

Responsible Party____ DOB:_______ Sex: _____

Address: _______________________________ City: ______________Zip: ________

Client's relationship (circle): Self Spouse Child Other:_________________

CIRCLE CONTACT PHONE OF YOUR CHOICE: Home Phone: (____)__________

Work Phone (____)_________ Cell Phone: (____)__________ Other: (____)_______________

EMERGENCY CONTACT:

Full Name:____ Phone Number: (____)__________________
Address:____ Cell Phone: (____) ______________________
Relationship to client:____

CONFIDENTIAL CLIENT INFORMATION

Client Name: ____

Children or Siblings (name, ages): ____

____

____

____

Are you currently receiving treatment for an illness, injury, or other medical condition? Yes No

If yes, what is the diagnosis and what are the treatments: ____________________

____

____

Are you currently taking any prescription or over-the-counter medications or illegal drugs? Yes No

If yes, please tell us the name and dosage of each medication: ________________

____

____

Legal Issues and History: Please tell us if you have any current legal issues (arrests, convictions, civil or criminal lawsuits, judgments, order of protection, bankruptcy, juvenile delinquency): ____________________

____

____

What are your goals for therapy? ____

____

____

____

The above information is true and correct to the best of my knowledge.

______________________________ ____________ Circle: Self Parent Spouse Other

Signature of person completing this page Date Your relationship to client