CLARITY  THOUGHT

CLIENT INFORMATION

Name_____ Age_____ Birth Date_____

Address_____

Preferred Phone_____ Other Phone_____

Social Security #_____

Referral From_____

Family (ages of parents, siblings, children)_____

_____

_____

Work History_____

_____

_____

_____

_____

Marital Status_____

Education_____

_____

Medical History _____

_____

_____

_____

_____

_____

_____

CLARITY  THOUGHT

Legal History_____

_____

_____

Smoke_____

Drink_____

Non-Prescribed Drugs_____

Prescribed Medications_____

_____

Psychological History_____

_____

_____

_____

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_____

_____

_____

Parents, Sibling, Children Medical/Psych/Drug History_____

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Signature_____ Date_____

Privacy Notice: The information provided on this form and during the sessions will be held in confidence except as needed for bill collection or as required by law.

Dr. Jay Glass • Laguna Beach, CA • (949) 371-7510