Jennifer Chen Speckman, LCSW
License #23659

CLIENT INFORMATION FORM

Client Name: _____

Today's Date: _____ Date of Birth: _____ Age: _____

Address: _____

Phone (H): _____ Phone (C): _____ Message ok? _____

Occupation: _____

Primary Care Physician: _____

Phone: _____

Psychiatrist: _____ Phone: _____

Health Conditions/ Significant Illnesses: _____

_____

Medications: _____

History of: ☐ ADD/ADHD ☐ Alcohol/ Substance Abuse ☐ Anxiety ☐ Behavior Problems
☐ Domestic Violence ☐ Depression ☐ Eating Disorders ☐ Emotional/Verbal Abuse
☐ Foster Placement ☐ Physical Abuse ☐ Sexual Abuse ☐ Other: _____

Previous Therapy/Mental Health Treatment:

_____

_____

Reasons for seeking services:

_____

_____

Emergency Contact: _____

Phone: _____