Mary Deger Seevers, MA, MFT
Marriage & Family Therapist

Client Information Form

Today's Date:_____Client Number:_____
Name:_____Age:_____Date of Birth:_____
Home Address:_____
Telephone(s):home:_____work:_____cell:_____
Email:_____fax:_____other:_____
Social Security Number:_____
Driver's License Number:_____
Insurance Company:_____ID#:_____
Address:_____
Group# or Other Important Insurance Info:_____
Referred by:_____
Your Employer:_____Your Occupation:_____
Employer's Address:_____
Length of Time Employed:_____
If married, Spouse's Name:_____Age:_____Date of Birth:_____
Spouse's Employer:_____Occupation:_____
Length of Time Together:_____ _____Telephone(s):_____
Person & Number to call in case of emergency:_____
_____
Family members and others living in your home:
Name/Relationship to you:_____Age:_____
_____Age:_____
_____Age:_____
_____Age:_____
_____Age:____

Your Parents/Step-Parents (name/age or year of death):
_____Location:_____
_____Location:_____
_____Location:_____
_____Location:_____

1720 South Amphlett Blvd. Suite 118 San Mateo, CA 94402
Tel: 650-655-2718 Fax: 650-655-2797

From whom/where do you receive medical care?_____
Clinic/Doctor's name:_____Phone:_____
Address:_____
Last visit:_____
Please list out for me all of your current medication(use the back of this page if necessary):

_____
_____
_____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate treatment?
Yes__No__
Have you been in therapy before?_____
If yes, approximately how many visits did you have with the therapist?
____less than a month_____less than a year____a year or more

Briefly state your reasons for seeking treatment:

_____
_____
_____
_____
_____
_____

Check any of the following that apply to you at this time:

___Headaches	___Alcohol Consumption	___Obsessive Thoughts
___Dizziness	___Feel Tense	___Shy Around People
___Fainting Spells	___Feel Panicky	___Lack of Friends
___Palpitations	___Tremors	___Loneliness
___Stomach Trouble	___Depression	___Indecisive
___Change in Appetite	___Suicidal Ideas	___Job Related Problem
___Bowel Disturbances	___Use of Drugs	___Inferiority Feelings
___Chest Pains	___Unable to Relax	___Financial Difficulties
___Fatigue	___Sexual Problems	___Feelings of Being Afraid
___Insomnia	___Uninterested in Vacations	___Compulsive Behavior
___Nightmares	___Fear of Leaving Home	___Unhappy Home Environment
___Use of Sedatives	___Over-Ambitious	

Is there anything not mentioned above that you think I ought to know?_____
_____
_____
_____