Margit Cox Henderson, Ph.D.
Licensed Clinical Psychologist

Client Information Form

_____ _____ ___ ___/___/___
Client's Last Name First Name M.I. Today's Date

_____ _____ _____ _____
Address City State Zip

_____ _____ _____
Home Phone Work Phone Cell Phone

____/____/____ Age: _____ Gender: _____ Text ok? ❒Yes ❒No
Birth Date

_____ Receive monthly blog? ❒Yes ❒No
Email Address

Marital/Relationship Status: _____ Ethnicity: _____

Religious Affiliation: _____ Years of Education: _____

Occupation: _____ Who referred you? _____

Brief Description of Presenting Problem for Therapy:
_____
_____
_____

Previous Counseling? ❒ Yes ❒ No
If yes, list providers names, dates and issues addressed: _____
_____

Previous Psychiatric Hospitalizations? ❒ Yes ❒ No
If yes, list hospital names, dates and issues addressed: _____
_____

Current Medical Issues: _____

Current Medications (including medical and/or psychiatric)? ❒ Yes ❒ No
If yes, list medications, dosages and name(s) of prescribing physician(s): _____
_____

In case of emergency, I authorize Dr. Henderson to contact:
Name: _____ Relationship: _____
Phone# _____ Address: _____

Client Signature: _____ Date: ____/____/____