Karen P. Williams, PhD
Client Information Sheet

Patient/Client Name	Address	Day/Evening Phone
First: Last:	Street: City, Zip:	Day ( ) Eve ( )

Date of Birth & Age	Marital/ Relationship Status	How long in current relationship	Education Level	Occupation

Social Security #	Driver's License #	Employer Name, Address & Telephone	May we contact you
		Street: City, Zip:	At Work? No Yes At Home? No Yes Circle one or both

Whom may we contact in an emergency?	Whom may we thank for referring you?
Name: Address: Phone: ( ) Relationship:	

Abbreviated Medical History		
Do you have any known allergies to food or drug? Please list: Do you have any drug allergies?		
Please list any surgical or significant medical history:		
Are you currently being treated by anyone else for a physical condition or mental health reasons? By whom? For?		
Who is your family or primary care physician (PCP)? Name: Address: Phone:		When was the last time you were seen by your PCP? Purpose:

Insurance Information

Primary Insurance Co:	ID#	Group#
Address:	City, State, Zip	
Primary Insured's Name	Primary Insured's Employer:	
Primary Insured's Social Security #	Primary Insured's Date of Birth:	
Secondary Insurance Co:	ID#	Group#
Address:	City, State, Zip	
Secondary Insured's Name	Secondary Insured's Employer:	
Secondary Insured's Social Security #	Secondary Insured's Date of Birth:	

Consent for treatment
I authorize mental health treatment for the above named client, and I agree to pay all the fees for those services received that the insurance does not cover. I agree that the information above can be used to bill my insurance company. _____ Signature and date