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3138 Butler Pike, Suite 200
Plymouth Meeting, PA 19462
484/530-0778 (office)
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Client Information

Thank you for choosing me as your/your child's mental health care provider. Please take moment to fill out the following information and bring with you to your first appointment.

Name (of primary client):_____

Name of parent(s) or guardian(s), if client is a minor: _____ /_____

Phone Number: (c) _____ (w) _____ (h) _____

Phone Number: (c) _____ (w) _____ (h) _____

Address:

_____

Email: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Insurance Type: _____ Insurance Number: _____

Client's School/Work:

_____

Grade: _____ Any special services in school?_____

Developmental/Cognitive Delays/504/IEP:

_____

How did you find out about my services?

Please briefly describe the concern you wish to address:

How would you like things to improve as a result of treatment?

Please list any medications your child is taking and the prescribing physician:

Prescription: _____ Physician: _____

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Has there ever been a history of:

Violence _____ , Sexual Abuse _____ , Substance Abuse _____

Suicidal Thinking _____ , Suicide Attempt (s) _____

If so, please explain:

Please list any additional comments you may find helpful:

Signature: _____ Date: _____