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CLIENT INFORMATION SHEET

Name: (Last) _____ (First) _____ (M.I.) _____

Home Phone _____ May I leave a message at this number? Yes No

Cell Phone _____ May I leave a message at this number? Yes No

Work Phone _____ May I leave a message at this number? Yes No

Email: _____ May I email you? Yes No

Home Address:

Street and Number: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Gender: _____

Legal status: (please circle) *Single* *Married* *Divorced* *Widowed*

Emergency Contact: _____ Phone: _____

Relationship to patient: _____

Primary Care Physician: _____ Phone Number: _____

Psychiatrist: _____ Phone Number: _____

Medications: _____

Major Medical Conditions: _____

Person responsible for payment (if not above)

Name: _____ Phone: _____

Address: _____

Client Signature: _____ **Date:** _____