Susan L. Reviere, PhD
Licensed Psychologist

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Client Information Form

Full Name _____ Name You Prefer to be Called_____

Age:_____ Date of Birth:_____

Address _____

_____

Alt Address (if above not permanent):_____

Home Phone (_____)_____ Okay to leave message? Yes / No

Work Phone (_____)_____ Okay to leave message? Yes / No

Cell Phone (_____)_____ Okay to leave message? Yes / No

Alternative Phone (_____)_____ Okay to leave message? Yes / No

Requesting: ____individual therapy _____couples therapy _____group therapy _____psychological testing/evaluation

Who referred you? _____ May I thank them? ____ yes ____no

Emergency Contact: Name _____

Address_____

Phone (_____)_____ Relationship to You _____

May I contact this person in the event of a clinical or nonclinical emergency? _____yes _____no

_____

Client Signature Date