1133 Broadway, Suite 1028 – New York, NY 10010
(646) 701-7990
www.mybestrelationship.com

CONFIDENTIAL CLIENT INFORMATION FORM – FOR INDIVIDUALS

CONTACT INFORMATION:

DATE:	
NAME:	
STREET ADDRESS:	
CITY, STATE, ZIP:	
DATE OF BIRTH:	
COUNTRY OF BIRTH:	
BEST CONTACT PHONE:	
OK TO LEAVE MSG?	
ALTERNATE PHONE:	
OK TO LEAVE MSG?	
EMAIL ADDRESS:	
OK TO EMAIL?	

DEMOGRAPHIC INFORMATION:

SEX:	
SEXUAL ORIENTATION:	
RELATIONSHIP STATUS:	
DO YOU HAVE CHILDREN?	
ETHNICITY:	
OCCUPATION:	
EMPLOYER:	

PAYMENT INFORMATION:

If you will be using in-network insurance, please provide your insurance ID number:

_____ Name of insured: _____

Co-pay: _____

If you have out of network insurance, please indicate what type of insurance you have:

_____ Name of insured: _____

CANCELLATION POLICY & CREDIT CARD INFORMATION:

Please give as much notice as possible if you need to cancel an appointment as your appointment time is specifically reserved for you.

If you cancel an appointment with less than 24-hours notice, or if you do not show for a scheduled appointment, you are responsible for the full fee for the session.

Please sign below to indicate that you are aware of this policy and agree to it.

Name (printed) Signature Date

Please indicate a credit card number to be kept on file to charge for missed or cancelled sessions with less than 24-hours notice.

Name on card:_____
CC#: _____
Expiration date: _____
CVV code: _____

By signing below, I authorize My Best Relationship Psychological Services, PLLC to charge the above credit card for a missed or cancelled session with less than 24-hours notice.

Name (printed) Signature Date

REFERRAL INFORMATION:

Current reasons for seeking psychotherapy at this time:

Please estimate how much the above issue(s) effect you right now:

□ Not upsetting
□ Mildly upsetting
□ Moderately upsetting
□ Very upsetting
□ Extremely severe
□ Totally incapacitating

How did you hear of my practice?

HEALTH INFORMATION AND HISTORY:

Have you previously received any type of mental health services (individual or couples psychotherapy, psychiatric services, etc.)?

□ Yes
□ No

If so, when and for how long?

For what issues?

Was/were your previous experience(s) with mental health services helpful?

□ Yes
□ No

If so, what was most helpful, and if not, why not?

Do you currently take any medication?

□ Yes
□ No

If yes, please list name of medication, dosage and prescriber:

Have you ever been hospitalized?

□ Yes
□ No

If yes, please indicate when and for what reason:

Please list any past/present drug and alcohol use. What have you used and how much, when was your last use, what do you currently use and how much?

MISCELLANEOUS:
How long do you think therapy should last (for you)?

What are your biggest worries or fears?

What do you consider to be your biggest strengths?

What are your major challenges at this time?

If you had 2 wishes, what would they be?

Please feel free to let me know any other information that might be helpful in our work together:

Thank you for taking the time to complete this form!