Michael Sherman, MFT

Client Information Sheet

Name _____ **Date of Birth** _____

Address _____ **Social Security #** _____

City _____ **Zip Code** _____

Telephone Home _____ **Work** _____

Cell Phone/Other _____

Occupation/Employer _____

Physician Contact _____

Medication(s)/Dosage? _____

_____

_____

Any prior counseling or therapy? Dates? Therapist(s) _____

_____

_____

Is there a family history of mental disorders/depression, etc.? _____

If yes, please explain _____

_____

_____

How were you referred to this office? _____

_____

Is there anything else the therapist should know? _____

_____

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