Holly Lien, LMFT
Licensed Marriage and Family Therapist
MFC35076

1736 Picasso Ave., Ste A
Davis, CA 95618
530-220-3433
holly@hollylien.com

Client Information Form

Name:_____ Gender: _____

Age:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip: _____ Email: _____

Phone (home):_____ (work):_____ (cell): _____

Marital Status: ☐ Single ☐ Married (date: _____) ☐ Separated (date: _____)

☐ Divorced (date: _____) ☐ Widowed (date: _____)

Referred by:_____

Children (names/ages): _____

With whom do they live?:_____

Name of person(s) financially responsible:_____

Address:_____ City:_____ State:_____ Zip:_____

Reason for seeking services:_____

_____

Emergency contact (name, relationship, & phone): _____

Medical History

Current Primary Care Physician (name & phone): _____

Date of last physical exam: _____ with whom:_____

Significant medical history (surgeries, accidents, illnesses, etc.): _____

_____

Past psychiatric medications (include names, dosages, dates taken, prescribing doctor(s), & response):

_____

Current medications (name, dosage, & date started): _____

_____

Prescribing doctor (name & phone number):_____

Chemical use history: (include age of onset, history, current usage)

Alcohol: _____

Street drugs: _____

Mental Health History

Previous mental health services ☐ Yes ☐ No Provider & Dates: _____

_____

Outcome of previous mental health services: _____

Previous psychiatric hospitalizations: ☐ yes ☐ no (if yes, please list dates and hospital):

_____

Previous Suicide Attempts: ☐ yes ☐ no (if yes, please list dates): _____

Additional Information

Please briefly explain any legal or criminal history: _____

_____

_____

Private Pay Client: *Note:* Please disregard the section below if you are not billing your insurance

Name of employer: _____

Name of your insurance company:_____

Insured's name:_____ Insured's date of birth:_____

Insured's ID#:_____ Group#:_____

Insured's address:_____ City:_____ State: ____ Zip:_____

Your relationship to the insured (check one): ☐ self ☐ spouse ☐ child ☐ other: _____

I hereby authorize the release of any medical or other information necessary to process medical insurance or EAP claims related to treatment. I authorize direct payment to Holly Lien, LMFT for insurance reimbursement of covered services.

Date:_____ Signature:_____