Holly Lien, LMFT
Licensed Marriage and Family Therapist
MFC35076

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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:____