GREGORY CASON, Ph.D.
Psychologist *License PSY15781*

CLIENT INFORMATION FORM

Name _____ **Date** _____

Date of Birth _____ **Age** _____

Home Address _____**Apt/Suite Number** _____

City _____ **State**_____ **Zip Code** _____

Mailing Address *(if different from above)*_____

City _____ **State**_____ **Zip Code** _____

Day Phone No. (_____)_____ **Night Phone No**. (_____)_____

Email (or other method of contact): _____

Contacts will be discreet, but it is best to write down telephone numbers and email addresses where you would feel comfortable receiving a call or email from me. If you have any special considerations (such as a roommate, business associate, or partner), please let me know.

Person to contact in case of emergency: _____

Relationship to you _____**Phone number** (_____)_____

Medical Clinic or Doctor's name: _____

Address: _____ **Phone: (**_____)_____

Are you currently taking any medications or receiving any medical treatments? YES NO

If yes, please list medications and/or treatments: _____

_____

Please list any current medical conditions *(if none, write "none")***:** _____

_____

EMERGENCY NOTIFICATION:
For most issues, I will get your permission before contacting your doctor, clinic, and/or emergency contact. But, in the event I believe there is a genuine *clinical emergency*, do you give me permission to notify your doctor, clinic, and/or emergency contact? YES NO

Where did you find out about this service? _____

If a person referred you, may I contact him/her and express thanks for the referral?
YES NO

By signing this document, I certify that all of the above information is true:

_____ _____
Signature Date