CLIENT DATA FORM - CONFIDENTIAL

Beth Levine, LCSW-C
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First Name: _____ Last Name: _____

Date of birth: _____ Have you been in therapy before? Yes_____ No_____

Occupation: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ (May I leave a message on this number?) ☐ Yes ☐ No

Work Phone: _____ ☐ Yes ☐ No Cell: _____ ☐ Yes ☐ No

E-mail: _____

Emergency Contact Person: _____

Phone (home/cell): _____

Address: _____

Relationship: _____

I give permission for Ms. Levine to contact this individual in case of an emergency.

_____ _____
Signature of Client Date

How did you hear about me? _____

Are you seeing another therapist or psychiatrist currently? ☐ Yes ☐ No

Name(s): _____

(Please fill out Release of Information form and I will discuss with you if it is necessary for me to coordinate treatment)