

Client Information Form

Personal Information

Client's Name: _____ Date of Birth: _____

Age: _____ Gender for Insurance: _____ Social Security #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ ☐ Home ☐ Cell ☐ Work Preferred Pronouns: _____

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things. 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

Feeling down, depressed, or hopeless. 0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day

Current Treatment Providers

Psychiatrist: _____ Physician: _____ Therapist: _____

Phone Number: _____

Current Medications: _____

Emergency Contact Information

Name: _____ Relationship: _____

Phone: _____ ☐ Home ☐ Cell ☐ Work

Insurance Information

 Please complete this section if you are planning to use private insurance for payment

Primary Insurance Company: _____

Name of Insured: _____ Insured's Date of Birth: _____

Insured's SS #: _____ Insured's Employer: _____

Subscriber/ID #: _____ Group #: _____

Secondary Insurance Company: _____

Name of Insured: _____ Insured's Date of Birth: _____

Insured's SS #: _____ Insured's Employer: _____

Subscriber/ID #: _____ Group #: _____

I authorize use of this information for all insurance submissions.

I authorize the release of information to my insurance company.

I understand that I am responsible for the full amount of my bill for services provided.

I authorize direct payment to Dr. Upton

Client Name: _____ Date: _____

Client Signature: _____