

**Client Application**

**Rosemary Smith, LMSW**

First Name Last Name Date

Address City State Zip

Home Phone Cell Phone Email Address

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male\_\_\_\_ Female\_\_\_\_

Single\_\_\_\_ Married\_\_\_\_ Other\_\_\_\_

Family Doctor Name/Phone\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name\_\_\_\_\_ Phone\_\_\_\_\_

**PERSON RESPONSIBLE FOR PAYMENT**

If Client is responsible for bills there is no need to re-enter information here, otherwise complete this section.

Title First name Last Name

Address City State Zip

Home Phone Business Phone Relationship to Client

**FAMILY INFORMATION**

Spouse\_\_\_\_\_DOB\_\_\_\_\_

If a minor, name of parent(s) or guardian(s)\_\_\_\_\_

Children of an adult, or siblings of a child client, and/or others living at home: (if more than 4 list on back)

First Name Last Name DOB In Home?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_