Psychological Sunrise Center, PLLC
Dr. Dina Reimer, Psy.D.
www.psychologicalsunrisecenter.com

CLIENT INFORMATION SHEET

Client:_____
Last Name First Name Middle

Date of Birth:_____ **Age:**_____ **Male ( ) Female ( ) Ethnicity (optional):**_____

Home Address:_____
Street Apt# City State Zip Code

Home Telephone#:_____ **Mobile Telephone#:**_____ **Email Address:**_____

Business Address of Client or Parents

Name of Firm:_____**Occupation:**_____

_____ **Telephone#:**_____
Street Suite# City State Zip Code

Single:_____ **Married/Date:**_____ **Widowed/Date:**_____ **Separated/Date:**_____ **Divorced/Date:**_____

Mother's Name (in full):_____ **Father's Name (in full):**_____

Spouse's Name: _____ **Stepparent's name(s) if applicable:** _____

Education:_____

(if applicable) Name of School:_____ **Grade:**_____

People currently living in household (relationship to client, age, occupation or grade level): _____

_____

Person to Notify in Case of an Emergency:_____ **Telephone#:**_____

Address:_____

Relationship to Client:_____

Referred By (please give source or name):_____ **Telephone#:**_____

Primary Care Physician:_____ **Date of Last Exam:**_____

Address:_____ **Telephone#:**_____

Previous and/or Other Psychiatric Care

Hospital or Individual	Location	Date(s)- month/year
		-
		-
		-

Form Completed By: _____ **Date:** _____

Relationship to Client: _____ **Okay to thank referral via phone/email/note? Yes No N/A**