Client Information Form

Date: ____

Name: ____

Address: ____

City: ____ State: ______________ Zip Code: _____________

Home Phone: __________________________Cell Phone: ______________________________________

Is it okay to leave a message? ____

Email Address: ____

Date of Birth* ____

Spouse or Partner's Name: ____

Address: ____

City: ______________________________________ State: ________________ Zip Code: _____________

Home Phone: ______________________________ Cell Phone: _________________________________

Is it okay to leave a message? ____

Email address: ____

Date of Birth: ____

Children

Name	Date of Birth	Age	

Laura Richter, Ph.D., LMFT
7777 Glades Road, Suite 207B, Boca Raton, Florida 33434
561 715-6404
drlaurarichter@gmail.com

Please provide names and dosages for medications of individuals participating in therapy.

Medication	Prescribed to	Dosage	Doctor

Have you ever attended therapy?

____

Was it helpful? ____

If yes, in what way? ____

____

Please check below for any stressors that you are experiencing.

☐ Financial ☐ Employment ☐ New Parent ☐ Legal ☐ Death/Loss ☐ Separation

☐ Divorce ☐ Substance Abuse ☐ Domestic Violence ☐ Health Issues

☐ Infidelity ☐ Other

If you have checked "other," please briefly explain:

____

____

Place a check in the box for any of the following that apply.

☐ Headaches ☐ Dizziness ☐ Fainting ☐ Heart Palpitations ☐ Stomach

☐ No appetite ☐ Unable to sleep ☐ Feeling anxious or unable to relax

☐ Feeling Sad ☐ Feeling depressed ☐ Difficulty making friends

☐ No ambition ☐ Suicidal thoughts

Please state why you decided to come to therapy.

____

____

____

Complete the following page if you are seeking therapy for a minor child. Both parent/guardians' names must be provided. Both parents must give consent for therapy.

Mother's Name: ____

Address: ____

City: ______________________________State: ______________ Zip: __________

Cell Phone: ________________________Home Phone: _______________________

Father' Name ____

Address: ____

City: _______________________ ______ State: _____________ Zip:__________

Cell Phone: ___________________________ Home Phone: ___________________

If parents are divorced, is there a time sharing/parenting plan in effect?

____

(*For children of divorced parents (minors), both parents must sign Informed Consent, indicating agreement that the minor child can be seen in therapy.*)

Laura Richter, Ph.D., LMFT
7777 Glades Road, Suite 207B, Boca Raton, Florida 33434
561 715-6404
drlaurarichter@gmail.com