Jennifer Ritchie-Goodline, Psy.D.
Licensed Clinical Psychologist

9085 East Mineral Circle | Suite 235 | Centennial, Colorado 80112 | Phone 720.299.8342 | Email

Client Information Sheet

Client Name:____Today's Date:____________

Name of Guardian(s) (if client is a minor):____

Address:____

City, State, Zip:____

Gender:___________ DOB:_____________ Age:________ SSN:______________________

Relationship Status: single married domestic partner separated divorced widowed

Occupation/Work Emphasis:____

Home Phone:_____________________________ Okay to contact you there?___________
Okay to leave a message?___________

Work Phone:______________________________ Okay to contact you there?___________
Okay to leave a message?___________

Cell Phone:_______________________________ Okay to contact you there?___________
Okay to leave a message?___________

Referred By:____

Emergency Contact Name:_____________________________ Phone:________________
Relationship to you:______________Okay to contact in the event of an emergency?____

Please list other people living in your household and their relationship to you:

____

____

____

____

Primary Insurance Information:

Insured Name:____

Insured DOB:________________________ Insured SSN:____________________________

Insured Employer:____

Payer/Health Plan:____

Your Relationship to Insured: self spouse dependent

Member Number:___________________ Policy/Group Number:___________________

Secondary Insurance Information:

Insured Name:____

Insured DOB:______________________ Insured SSN:__________________________

Insured Employer:____

Payer/Health Plan:____

Your Relationship to Insured: self spouse dependent

Member Number:___________________ Policy/Group Number:___________________

Please present insurance card(s) to me, so that I can make a copy.

Please describe your reason(s) for seeking treatment at this time. If there is a particular event that triggered your decision to seek treatment now, please list the event:____

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Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of you life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Relationship						
Family						
Job/School						
Friendships						
Finances						
Physical Health						
Anxiety Level						
Mood						
Eating Habits						
Sleeping Habits						
Alcohol/Drug Use						
Sexual Functioning						
Ability To Concentrate						
Ability To Control Anger						

What result(s) do you expect from treatment? ___________________________________