LIFE CHOICES ONLINE
CLIENT DATA FORM

Name:____DOB:__________

Address:____________________, City_______________, State/Zip___________

Contact Phone: (to be used for sessions)__________________________________
License Number and State:____
Please remember to send a copy of license to verify state as services are offered only in Pennsylvania at this time.

Emergency Contact:______________________Phone:__________Relationship:________________________

Currently being treated by a physician: Yes or No   By a psychiatrist: Yes or No
Presently taking medications: If yes, please list___________________________or No___
Please note Medication Name, Dosage, Frequency, and length of time you have been taking medication:

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Any Medical Problems: If yes, please list___________________________________or No __

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Why are you seeking therapy? :____

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Do you use substances not prescribed for you or abuse prescribed medications?

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Any hospitalizations for mental health or substance abuse issues?_________________________________

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Have you ever tried to harm yourself, felt suicidal, or wished to harm another person? Or are you currently experiencing these feelings?

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