**CLIENT INFORMATION FORM**

**Gillian Nathan, LCSW**
**2120 Market Street, Suite 109**
**San Francisco, CA 94114**
**(415) 820-1603**

| First Name | Last Name | Birth Date | Age |
|---|---|---|---|
| Street Address | City | State | Zip |
| Telephone | Other Phone | Relationship Status | Ethnicity |
| Person to notify in case of emergency | | Telephone | Relationship |
| Name and ages of children | | school | |
| Present or past employer | Position/ Occupation | | |
| Primary Care Physician | Psychiatrist | | |
| Email | Referred By | | |

Past or present major health issues (including medications)?_____

_____

_____

Drug/alcohol history_____

_____

Have you ever been in therapy before?_____

_____

Anything else you would like me to know? _____

_____

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