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Kentfield, CA 94904

CLIENT QUESTIONNAIRE

YOUR ANSWERS BECOME PART OF YOUR CONFIDENTIAL MEDICAL RECORD.

Please complete the following information before your first appointment if possible. Please take the time to fill out this form carefully. This will help me understand the problems for which you are seeking help and make sure that you receive the best possible treatment.

TODAY'S DATE ____/_____/_____

Name: _____ **Date of Birth: _____ Gender:** ☐ **M** ☐ **F**

Address: _____

Phone: H: ( ) _____W: ( ) _____ C: ( ) _____

May we call you at home? ☐Yes ☐ No Work? ☐Yes ☐ No On your Cell? ☐ Yes ☐ No

May we leave a message from the clinic at home? ☐Yes ☐No Work? ☐Yes ☐No Cell? ☐ Yes ☐ No

Can we mail information to you at your home address? ☐ Yes ☐ No

Emergency Contact Information: Name of person to contact in an emergency

Name _____ Address: _____

Phone: H ( ) _____W ( ) _____ Relationship to you: _____

Background Information

Ethnicity (please check):	**Marital Status**:	**Sexual Orientation** *(Optional)*:
☐African American	☐Never married	☐Bisexual
☐Asian American	☐Living together, not married	☐Gay/Lesbian
☐Caucasian	☐Married	☐Heterosexual
☐Hispanic	☐Divorced	☐Transgender
☐Native American	☐Widowed	
☐Pacific Islander	☐Separated	
☐Other (please specify) _____		

Education: (Highest grade/degree completed) _____

Employment History

Currently employed? ☐Yes ☐No Longest Period of Employment in past (months, years _____

(If employed) Current Occupation: _____

Current Employer/Company: _____

Approx. Annual Income $_____Annual Household Income $_____ Total Number of Dependents: _____