Client Demographics

Client Name: _____

Gender: Male:_____ Female: _____ Transgender _____ Nonbinary_____ Other_____

Relationship Status: Married _____ Single _____ Other: _____

Preferred phone #:_____

Address: _____

Zip Code: _____

Client's D.O.B. _____ Client's SS#:_____

Email address: _____

Are you interested in receiving emails receipts/newsletter from Lynn? Yes No

Prior Treatment

Outpatient: Yes_____ No _____ If Yes, Where _____ Dates_____

How Long? _____

Inpatient: Yes _____ No_____ If Yes, Where _____

Date/s_____ How Long _____

Client Information

Why Are You Seeking Services At This Time?

_____

_____

_____

When Were You Last Seen By Your Personal Physician/Pediatrician?

_____

Who Is Your Primary Physician? _____

(Address) _____

_____

Have You Had Any Health Problems In The Last Year? Yes _____ No _____

If Yes, Please Explain _____

Are You Currently Taking Any Medications? If so, Please List:

_____

_____

_____

List Any Family Members Living In Your Home:

1. _____ Relationship To Client _____
2. _____ Relationship To Client _____
3. _____ Relationship To Client _____
4. _____ Relationship To Client _____
5. _____ Relationship To Client _____

What are the outcomes that you would like to experience in your life as a result of our work together? (the more specific and detailed, the better)

_____

_____

_____

_____

_____

_____