Ron Anders, LICSW

1424 Fourth Avenue ♦ Suite 831 ♦ Seattle, Washington 98101 ♦ (206) 621-8788 ♦ andersron@yahoo.com

CLIENT INFORMATION FORM

Name_____ **Date**_____

Address_____ **City/State**_____ **Zip**_____

Can you receive mail at this address? (circle one) Yes No

Phone No. _____ **Can you receive messages at this phone number? (circle one) Yes No**

Email address _____ **Can you receive messages at this email address? (circle one) Yes No**

Age_____ **Date of Birth**_____

How were you referred to this office?_____

(If you wish to use medical insurance:)

Insurance Company_____ **ID#**_____ **Group #**_____

Person to contact in case of emergency:

Name_____ **Address**_____

Phone No. _____ **Relationship**_____

Previous counseling/psychotherapy/self-help programs_____

_____

Educational Background_____

Occupation_____

Describe your use of tobacco, alcohol and drugs_____

If you are currently (or have been) on medication, please describe:_____

_____

Name of Physician_____ **Phone**_____ **Date of last physical exam**_____

Any additional significant information:_____

_____