THE ATTACHMENT AND TRAUMA CENTER OF NEBRASKA

Therapist________________________ Date________________

CLIENT INFO:

Name:______________________________ Address:_____________________________________

City/State/Zip_______________________________________ email__________________________

Home#_________________________Cell#______________________work#___________________

Date of birth:_________________ Age:_______ Circle: M/F Status: M/D/W/S/Student

Employed_____ Unemployed______Stay-at-home______Disability_______Soc.Sec.#____________

Occupation/Employer Name:____

Spouses Name_____________________________________ Date of Birth_____________________

Spouses Occupation/Employer Name____

INDIVIDUAL RESPONSIBLE FOR INSURANCE:

Relationship to client: Self_______ Parent________ Spouse_________ Other_________________
(skip to next session)

Name_______________________________________ DOB_____________Soc.Sec.#_______________

Employer Name:____

FOR MINOR CLIENT:

Name of Parent/Guardian___________________________________ Home phone_______________
Address if different____Cell phone_________________
Work phone_________________

Children:_____________________________age______________ How did you get to our office?
______________________________age______________ Professional__________________
______________________________age______________ Insurance/EAP________________
______________________________age______________ School:_______________________
______________________________age______________ Web/Phone book_______________
______________________________age______________ Word of mouth/ other___________

Emergency Contact: name/relation____
Phone/address:____
Physician/clinic name____
MD phone/address____