



A BETTER LIFE THERAPY, LLC

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New Client Information Form

Today's Date: _____

Last Name: _____ First Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Numbers: (H) _____ (W) _____ (C) _____

E-mail Address: _____

DOB: _____ Gender: _____ Marital Status/Partnered Relationship: _____

Ethnicity: _____ Religious Affiliation (if any): _____

Occupation: _____ Employer: _____

Partner's Ethnicity: _____ Partner's Employer: _____

Partner's Occupation: _____

Children/ Dependents: _____

Briefly describe your reason or seeking help:

Previous Therapy: Have you ever received psychiatric, psychological or counseling help before? _____

If so, briefly describe: _____

Have you ever been hospitalized for a psychiatric condition? _____ If Yes, When? _____

What was the situation? _____

Are you currently taking any prescribed medications? _____ If so, what? _____

For: _____ Prescribed by: _____

Have you taken prescription medications in the past? _____ If so, what? _____

For: _____ Prescribed by: _____

Are you being treated for any ongoing issues? _____

Emergency Contact: _____ Phone: _____

Relationship: _____

How did you hear about me? _____