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Client Information Sheet

Client Name: _____ Today's Date: _____

Name of Guardian(s) (if client is a minor): _____

Address: _____

City, State, Zip: _____

Gender: _____ DOB: _____ Age: _____ SSN: _____

Relationship Status: single married domestic partner separated divorced widowed

Occupation/Work Emphasis: _____

Home Phone: _____ Okay to contact you there? _____
Okay to leave a message? _____

Work Phone: _____ Okay to contact you there? _____
Okay to leave a message? _____

Cell Phone: _____ Okay to contact you there? _____
Okay to leave a message? _____

Referred By: _____

Emergency Contact Name: _____ Phone: _____
Relationship to you: _____ Okay to contact in the event of an emergency? _____

Please list other people living in your household and their relationship to you:

Primary Insurance Information:

Insured Name: _____

Insured DOB: _____ Insured SSN: _____

Insured Employer: _____

Payer/Health Plan: _____

Your Relationship to Insured: self spouse dependent

Member Number: _____ Policy/Group Number: _____

Secondary Insurance Information:

Insured Name: _____

Insured DOB: _____ Insured SSN: _____

Insured Employer: _____

Payer/Health Plan: _____

Your Relationship to Insured: self spouse dependent

Member Number: _____ Policy/Group Number: _____

Please present insurance card(s) to me, so that I can make a copy.

Please describe your reason(s) for seeking treatment at this time. If there is a particular event that triggered your decision to seek treatment now, please list the event: _____

Please indicate how the issue(s) for which you are seeking treatment are affecting the following areas of you life:

	No Effect	Little Effect	Some Effect	Much Effect	Significant Effect	Not Applicable
Relationship						
Family						
Job/School						
Friendships						
Finances						
Physical Health						
Anxiety Level						
Mood						
Eating Habits						
Sleeping Habits						
Alcohol/Drug Use						
Sexual Functioning						
Ability To Concentrate						
Ability To Control Anger						

What result(s) do you expect from treatment? _____
