Set Free Play Therapy
Carly Keaten MA, LPC
carly@setfreeplaytherapy.com
(720) 449-6736
1928 E 18th Ave.
Denver, CO 80206

Client Information Form

Today's Date:_____

Clients Name:_____

Address:_____

City, State:_____ Zip Code:_____

Date of Birth: _____ Age: _____ Gender: _____ Grade Level: _____

School: _____School Address:_____

City, State:_____Zip Code:_____

Home Phone:_____ Cell Phone:_____

Parent Work Phone:_____ Email: _____

RESPONSIBLE PARTY (PARTIES):

Legal Guardian: _____ Date of Birth:_____

Occupation:_____ Phone (if different): _____

Relationship to Child (check one): ( ) Mother ( ) Father ( ) Other: _____

Legal Guardian: _____ Date of Birth:_____

Occupation:_____ Phone (if different): _____

Relationship to Child (check one): ( ) Mother ( ) Father ( ) Other: _____

StepParent/ Caregiver
Name & Phone:_____ Relationship:_____

StepParent/ Caregiver
Name & Phone:_____ Relationship:_____

REFERRAL SOURCE:

Name/Source: _____ Phone: _____

May I have your permission to thank this person for referring me: ( ) Yes ( ) No

MEDICAL INFORMATION:

What is the name of your child's primary care physician? _____

Address: _____ Phone: _____

Date of your child's last medical examination: _____

Is Client taking any prescription medications? ( ) Yes ( ) No

If yes, please list names and dosages:

Is Client taking any nonprescription medications? ( ) Yes ( ) No

If yes, please list names and dosages:

□ = Current (within the last month)	○ = Past (one month ago or longer)
□ ○ change in appetite	□ ○ feelings of restlessness
□ ○ frequent or severe headaches	□ ○ dizziness or fainting spells
□ ○ significant weight gain/loss	□ ○ trembling or shaking
□ ○ eye or sight problems	□ ○ accelerated heart rate
□ ○ change in mood	□ ○ shortness of breath/ asthma
□ ○ irritability	□ ○ thyroid trouble
□ ○ feelings of worthlessness	□ ○ epilepsy or seizures
□ ○ changes in sleeping patterns	□ ○ sweating
□ ○ loss of energy	□ ○ chest pain
□ ○ loss of interest in activities	□ ○ feelings of choking
□ ○ increase of energy	□ ○ nausea
□ ○ difficulty concentrating	□ ○ deviant or unusual sexual behavior
□ ○ nightmares	□ ○ recurrent thoughts of wanting to commit suicide
□ ○ mother substance abuse during pregnancy (alcohol/smoking/drugs) specify:_____	□ ○ recurrent thoughts of harming others
	□ ○ cutting or burning myself
□ ○ problems with attention, motivation, memory	□ ○ seeing things that others do not
□ ○ recurrent and excessive anxiety or worry	□ ○ hearing voices that others do not
	□ ○ paranoid thoughts

Please list any other disease or physical symptom not listed above:

NAME	M/F	AGE	DATE OF BIRTH	MARITAL STATUS	RELATIONSHIP TO CLIENT	EDUCATION	OCCUPATION
Patient (s):							
1.							
2.							
Parent (s):							
1.							
2.							
Siblings:							
1.							
2.							
3.							
4.							
5.							
Others in Home:							
1.							
2.							
3.							
4.							
5.							
6.							

_____

Printed Name

_____ _____

Signature Date