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CLIENT INFORMATION FORM

Date: _____

Client Name: _____ Date of Birth: _____
Address: _____ City _____ State _____ Zip _____

Social Security #: _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____

Emergency Contact Name: _____ Relationship to Client: _____
Phone Number: _____

Who referred you?: _____

Please briefly describe what brings you in today?:

Previous Counseling and/or Psychiatric Treatment:
(Please include name of provider, length and focus of treatment)

Medications (Please include dosages if known):

FOR CLIENTS 18 AND YOUNGER:

Legal Guardian Name: _____
Address: _____ City _____ State _____ Zip _____

Social Security #: _____

School: _____ Grade: _____

Emergency Contact Name: _____ Relationship to Client: _____
Phone Number: _____

Medications (Please include dosages if known):

AS YOU KNOW, SARAH E. BURGAMY, PSY.D. CONDUCTS A PRIVATE PAY PRACTICE AND DOES NOT DIRECTLY BILL INSURANCE COMPANIES. PLEASE INDICATE IF YOU WILL BE SUBMITTING BILLING STATEMENTS TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT: Yes: _____ No: _____