



PHOENIX RISE

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490 South Logan Street
Denver, CO 80209

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):

[Continued on next page]

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, **PhoenixRISE and SARAH E. BURGAMY, PSY.D.** CONDUCT A PRIVATE PAY PRACTICE AND DO NOT DIRECTLY BILL INSURANCE COMPANIES. PLEASE INDICATE IF YOU PLAN ON SUBMITTING BILLING STATEMENTS TO YOUR INSURANCE COMPANY FOR REIMBURSEMENT: Yes: _____ No: _____