Susan L. Charney, LCSW
6619, N. Scottsdale Road, Ste 21
Scottsdale, AZ – 85250
Phone 480-467-0223
Fax 480-467-0249

PATIENT INFORMATION DATE ____________

Name ______________________________________ Age/DOB ____________

Address ____________________________ City__________ State ________ Zip_____

Home Phone ________________________ OK to leave message? Yes _____ No _____

Work phone ____________________ OK to receive calls at work? Yes _____ No _____

Cell __________________________ OK to leave message? Yes _____ No _____

Email address ____________________________________

Sex ___________ Marital Status __________________________

Occupation ___________________Employer _______________________________

FAMILY INFORMATION

Family members (Spouse/Partner and Children)

Name _________________ Age ___ Relationship __________ Occupation __________

Name _________________ Age ___ Relationship __________ Occupation __________

Name _________________ Age ___ Relationship __________ Occupation __________

Name _________________ Age ___ Relationship __________ Occupation _________

Referred By _____________________________________

Primary Physician ________________________________ Phone No. _____________

Emergency Notification ____________________________ Phone No. _____________

Briefly describe your reason for contacting me: ______________________________

What counseling have you had before? _____________________________________

Any Medical Conditions? _____________________________ _________________

Current Medications ____

INSURANCE INFORMATION

Insured Party ____________________________ Relationship__________________

Insurance _________________ Group Name ______________ Group Policy ________

ID # ___________________ Address ______________________ Phone ___________