

DORIS M. DOMINGUEZ, MSW, LCSW

INITIAL INTERVIEW FORM

Date: _____

CLIENT INFORMATION:

Name: _____

Phone: (Cell) _____ (Hm) _____ (Wk) _____

Address: _____ City: _____

State: _____ Zip: _____

May I have permission to mail to this address? Yes _____ No _____

Sex: Male _____ Female _____ Date of Birth: _____

Marital Status: Single _____ Married _____ Separated _____

Divorced _____ Widowed _____

If married: Spouse's Name: _____ Phone: _____

Others living at home: _____

Employer: _____ Occupation: _____

How long have you worked there? _____ How long in this occupation? _____

Education: (List highest level of education attained) _____

Have you been involved in an accident lately? _____

Are you currently involved or have been named in a legal law suit? _____

Have you seen this type of therapist before? YES _____ NO _____

If yes, when and with whom? _____

Give a brief description of treatment: _____

Who may we thank for referring you? _____

Nearest relative other than spouse: _____

FINANCIALLY RESPONSIBLE PERSON'S INFORMATION:

Name: _____ Relationship to Client: _____

Phone (if different from above): _____

Address (if different from above): _____

Insurance Carrier (if applicable): _____

Social Security Number of Insured: _____

Group Number: _____ Member Number: _____

Insurance Phone Number: _____