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: ______________________