DBT CENTER OF MARIN
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Client Information Form

Name_____Date_____

Address_____City_____ Zip_____

Cell Phone_____ May I leave a message?_____ Text you?_____

Home/Work Phone (circle one)_____ May I leave a message?_____

Email_____ May I email you?_____

Sex: Male/Female (circle one) Date of Birth ___ / ___ /_____

Currently Employed? _____ Occupation _____

Employer/School_____

Employer/School Address _____ City_____

Relationship Status (circle one):
*Single *In Relationship *Married *Domestic Partnership *Separated *Divorced *Widowed

Please list any family members or significant others who may be involved in your treatment or payment for services:

Name_____ Relationship _____Phone _____

Name_____ Relationship _____Phone _____

Emergency Contact_____ Relationship _____Phone _____

Are you currently seeing a therapist? Yes/No (circle one) If yes:

Name_____ Phone_____

Address_____ City_____ Zip_____

Are you currently seeing a psychiatrist? Yes/No (circle one) If yes:

Name_____ Phone_____

Address_____ City_____ Zip_____

How did you hear about the DBT Center?_____