CLIENT DEMOGRAPHIC INFORMATION SHEET

TRANSITIONAL ANGER MANAGEMENT, LLC

NAME: _____

CHART NO:
Intake Date:

PHONE: Daytime: _____ *OK to leave message:* *Y* *N*
Evening: _____ *OK to leave message:* *Y* *N*
Other: _____ *OK to leave message:* *Y* *N*

Dx Code:
Clinician:

ADDRESS: _____
_____
_____

BIRTH DATE:
SS#:
SEX: *M* *F*

MARITAL STATUS: *Single* *Married* *Separated* *Divorced* *Widowed*

EMPLOYMENT STATUS: *Full-Time* *Part-Time* *Student* *Unemployed* *Retired*

PLACE OF WORK: _____
POSITION: _____

ETHNICITY:
YEARS OF EDUCATION:

RESPONSIBLE PARTY: _____
ADDRESS: _____
_____

HOME PHONE:
WORK PHONE:

REFERRED BY: _____

CONSENT FOR TREATMENT

I, the undersigned, have voluntarily applied for and agree to participate in counseling, psychological, and/or psychiatric services. I hereby authorize Transitional Anger Management, LLC to release treatment and psychological information to my primary medical physician if necessary. I understand that I am fully responsible for all fees relating to my treatment which are not covered by my insurance plan, and I further agree to pay my co-payment at the time of each visit.
In the event that I miss an appointment or cancel an appointment with less than 24 hours notification, I understand that I am solely responsible for paying session fees. Furthermore, if I fail to appear for three consecutive scheduled appointments, my case may be placed on inactive status.

_____ _____
Client signature Date