



Mary E. Senn, LCSW, ACSW
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Confidential Client Information

Today's Date: _____

Name: _____ D.O.B. _____

Address: _____ City _____ Zip _____

Telephone: Home _____ Cell _____ Work _____
(please circle preferred number)

Occupation: _____ Relationship Status: _____

Emergency Contact: _____ Phone: _____

Referred by: _____

May I use your name when I thank the person who referred you? Yes _____ No _____

Briefly describe what brings you to therapy: _____

Have you been in therapy before? _____ If so, when? _____

Have you ever had a psychiatric hospitalization? _____ If so, when? _____

Please describe any history of alcohol/substance abuse. What is your current usage? _____

Please describe any history of suicidal ideation/attempts. _____

Are you currently being treated for a medical problem? _____ If so, what? _____

Please list any medications and/or supplements that you are currently taking: _____

Please describe any forms of exercise you engage in: _____

Please describe your spiritual beliefs or practices: _____

INSURANCE INFORMATION

Please indicate primary insurance		ID#
Subscriber's Name (if different from patient)		
Patient's Relationship to Subscriber	Subscriber Birth Date	Subscriber SS#
Has deductible been met? Y/N		

The above information is true to the best of my knowledge. I authorize that my insurance benefits, if applicable, be paid directly to Mary E. Senn, LCSW, ACSW. I also authorize Mary E. Senn and/or insurance company to release any information required to process my claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization in writing at any time.

CLIENT SIGNATURE

DATE