

**Valeska Cosci, LCSW**  
2730 Wilshire Blvd. Suite 250  
Santa Monica, CA 90403  
(310) 862-4248  
LCS 21748

## Client Information Form

Today's date: \_\_\_\_\_

*Note:* If you have been a client here before, please fill in only the information that has changed.

### A. Identification

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Nicknames or aliases: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home street address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home/evening phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

Calls or e-mail will be discreet, but please indicate any restrictions: \_\_\_\_\_

### B. Referral: If this is a referral, please share the person who referred you:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

May I have your permission to thank this person for the referral?  Yes  No

If this is not a referral, how did you hear about me?  Web Search  Google Ad  PsychologyToday.com  Other

### C. Religious and racial/ethnic identification

Current religious denomination/affiliation  Protestant  Catholic  Jewish  Islamic  Buddhist

Hindu

Other (specify): \_\_\_\_\_

Involvement:  None  Some/Irregular  Active

How important are spiritual concerns in your life? \_\_\_\_\_

Which (if any) church, synagogue, temple, or meeting are you involved with? \_\_\_\_\_

Ethnicity/national origin: \_\_\_\_\_ Race: \_\_\_\_\_ or other similar

way you identify yourself and consider important: \_\_\_\_\_

**D. Your medical care: From whom or where do you get your medical care?**

Clinic/doctor's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

If you enter treatment with me for psychological issues, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?  Yes  No

Are you currently taking any medications? If yes, please list: \_\_\_\_\_

\_\_\_\_\_

**E. Your current employer**

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Work phone: \_\_\_\_\_ or other means of communication \_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

**F. Emergency information**

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Significant other/nearest friend or relative not residing with you: \_\_\_\_\_

**G. Insurance Information**

Please complete the following information only if you want to follow up with your insurance carrier for reimbursements. This information will be used to create a "Superbill" which will be provided to you for submission to your insurance.

Policy Holder: \_\_\_\_\_ Relationship to Policy Holder: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Member ID: \_\_\_\_\_

Group Number: \_\_\_\_\_ Your Social Security #: \_\_\_\_\_

**H. Prior Treatment**

Have you been treated for mental health services before? \_\_\_\_\_

\_\_\_\_\_

If yes, what dates and with whom? Please list treating clinician's name: \_\_\_\_\_

\_\_\_\_\_

**I. Chief Concern**

Please describe the main difficulty that has brought you to see me: \_\_\_\_\_

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**H. Is there any other information you would like to share?** \_\_\_\_\_

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