Jennifer Rodgers, LCSW, LLC
130 Montowese Street
Branford, CT 06405
(203) 533-1215

Name of Client: _____ DOB: _____

Address: _____ Age: _____

_____ Ethnicity: _____

Home Phone: _____ Living with: _____

Client Cell phone (if applicable): _____ Adopted: _____

Religion: _____

Parent/Guardian: _____ Parent/Guardian: _____

Address: _____ Address: _____

_____ _____

Home Phone:_____ Home Phone: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

Work Phone: _____ Work Phone: _____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Do you allow J. Rodgers to leave voicemails on the numbers provided? Yes ___ No ___
Do you allow J. Rodgers to send emails** to the addresses provided? Yes ___ No ___
**Please be advised that email is not considered a secure way of communication.

Parental Marital Status:
___ Married
___ Divorced
___ Separated
___ Widowed
___ Never Married

DCF involvement (y/n): _____
If yes, caseworker's name _____

Other family members:

Name	Age	Relationship	Live at home (y/n)

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Pediatrician: _____/ phone: _____

Psychiatrist: _____/ phone: _____

Other provider: _____/ phone: _____

Other provider: _____/ phone: _____

Education

Name of school: _____ Grade: _____

School address: _____ Phone: _____

Insurance Information

Policy Holder's Name: _____ DOB: _____

Insurance Company: _____ Policy Holder's SSN: _____

Member ID: _____ Group Number: _____

Claims Address: _____

Emergency Information

Name of emergency contact: _____ / phone: _____

Preferred hospital: _____

Brief Medical History

Current illnesses or conditions: _____

_____

Special medical considerations: _____

Medical history (i.e. hospitalizations, emergency room visits): _____

_____

Last seen by Primary Care Physician _____ Date of last physical exam: _____

Past behavioral health services/treatment:

Dates	Provider/Agency	Focus of treatment

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Current Medications

Name	Dosage	Frequency	Effectiveness	Side Effects	Prescriber

Previous Medications

Name	Dosage	Frequency	Effectiveness	Side Effects	Prescriber

Allergies or drug reactions

Drug/Allergy	Type of Reaction	Date

Parent/Guardian Signature _____ ***Date*** _____