

Ryan Parker, LCSW
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4111 Medical Parkway, #201
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(512) 387-7108

CLIENT INFORMATION FORM

Child's Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Caregiver Name: _____ Age: _____

Occupation/Employer: _____

Parent/Caregiver Name: _____ Age: _____

Occupation/Employer: _____

Siblings (please include names and ages): _____

Other important people in child's life: _____

(Please indicate preferred phone number to contact you)

Cell Phone: _____

Okay to leave message? ☐ Y ☐ N

Home Phone: _____

Okay to leave message? ☐ Y ☐ N

Work Phone: _____

Okay to leave message? ☐ Y ☐ N

Email: _____

Child's School: _____ Grade: _____

Teacher: _____ Teacher's phone: _____

Emergency Contact Name: _____ Phone: _____

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How did you find out about us?

Referred by: _____

☐ TherapyATX website

☐ Psychology Today

☐ Other: _____

Reason for seeking psychotherapy?

What cultural information would be important for me to know about you and/or your child?

(racial/ethnic identity, class identification/history, gender identity, sexuality, religious/spiritual preferences, important values/beliefs):

Has your child ever been in therapy before? Please describe:

Is your child currently taking any medications? If so, please list names of medications, doses, and reasons for taking medications:

Name of current prescribing doctor: _____

Phone number of current prescribing doctor: _____