

**Ellen M. Greenfield, Ph.D.**  
Licensed Psychologist –PSY 15279  
9663 Tierra Grande, Suite 104  
San Diego, California 92126  
(619) 840-5045

## **CLIENT INFORMATION**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

OCCUPATION \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_

SPOUSE OR CLOSE RELATIVE \_\_\_\_\_  
(OR PARENT IF CLIENT IS MINOR)

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

HEALTH INSURANCE \_\_\_\_\_  
(Give group and membership number, policy number and/or claim number)

SPOUSE EMPLOYED BY \_\_\_\_\_  
(If spouse is primary name on the insurance)

PRIMARY PHYSICIAN \_\_\_\_\_

REFERRED BY \_\_\_\_\_

If you were referred, may I acknowledge the referral? Yes \_\_\_\_\_ No \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_