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**Client Information Form**

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

**A. Identification**

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

Age: \_\_\_\_\_

Home street address: \_\_\_\_\_

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

Home/evening phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_

**B. Referral: Who gave you my name to call?**

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

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

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

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

Current Medications: \_\_\_\_\_

**D. Emergency information**

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

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

Relationship: \_\_\_\_\_