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INITIAL INTERVIEW FORM

CLIENT INFORMATION:

Name: _____ SS#: _____

Phone: (C) _____ (Hm) _____ (Wk) _____

Sex: M F DOB: _____ Married () Partner () Single () Divorced ()

Address: _____

City: _____ State: _____ Zip: _____

Name of Spouse/Partner: _____

Employer: _____ Occupation: _____

RESPONSIBLE PARTY FOR THE BILL (If other than patient):

Name: _____ Relationship to Client: _____

Phone (if different from above): _____ SS#: _____ DOB: _____

Address (if different from above): _____

Insurance Carrier (if applicable): _____

SS#: _____ Deductible: YES__NO _____

Employer: _____ Occupation: _____

Primary Physician: _____ Phone: _____

List any significant health problems: _____

List any medications you are taking and the dosage: _____

Have you seen a therapist before? YES _____ NO _____

If yes, when and with whom? _____

Give a brief description of treatment: _____

How were you referred to my office? _____

Who may I thank for referring you? _____