Artful Aging
Annie Holscher, ATR-BC, LCPAT, CDP
6203 Executive Blvd, Rockville, MD 20852
301.859.0440

Client Information Form

Today's date: _____

Client's full name: _____ Date of birth: _____
Preferred Name: _____ Administrative Sex: ❑ Male ❑ Female
Preferred Gender Identity: _____. Preferred Pronouns: _____

Home street address: _____
City: _____ State: _____ Zip: _____
Preferred phone #: _____ e-mail: _____
Calls or e-mail will be discreet, but please indicate any restrictions: _____
❑ Voicemail OK ❑ Text Messages OK

Power of Attorney or Responsible Party (if applicable):_____
Relationship to Client:_____
Home street address: _____
City: _____ State: _____ Zip: _____
Preferred phone #: _____ e-mail: _____
Calls or e-mail will be discreet, but please indicate any restrictions: _____
❑ Voicemail OK ❑ Text Messages OK

Payment Information:
❑ Private Pay - Responsible Party: _____
❑ Insurance - Provider Name:_____
Policy #_____
Group #_____
Name of Insured (Policy Owner) _____ Insured's DOB:_____

Referral: Who gave you my name to call?
Name: _____
May I have your permission to thank this person for the referral? ❑ Yes ❑ No
How did this person explain how I might be of help to you? _____
_____

Religious and racial/ethnic identification
Current religious denomination/affiliation ❑ Protestant ❑ Catholic ❑ Jewish ❑ Islamic ❑ Buddhist ❑ Hindu
Other (specify): _____
Involvement: ❑ None ❑ Some/irregular ❑ Active
How important are spiritual concerns in your life? _____

Which (if any) church, synagogue, temple, or meeting are you involved with? _____

Ethnicity/national origin: _____ Race: _____ or other similar way you identify yourself and consider important: _____

Your medical care: From whom or where do you get your medical care?
Facility/doctor's name: _____ Phone: _____
Address: _____
If you enter treatment with me, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Important medical information (Including allergies):

_____
_____
_____
_____

Your goals for art therapy treatment:

_____
_____
_____
_____
_____
_____

Prior experience with art:

_____
_____

Employment , Educational, and/or military history:

_____
_____
_____

Family medical/psychological history:

_____
_____
_____
_____

Is there any other information you'd like me to know?

_____
_____
_____
_____
_____
_____
_____