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



## **Client Information Form**

Client's full name: Administrative Sex: Male Female Preferred Name: Administrative Sex: Male Female Preferred Gender Identity: Preferred Pronouns:	Preferred Name: Preferred Gender Identity:  Home street address:  City: Preferred phone #:e-i	Administrative Sex:  Mal	le 🗆 Female
Preferred Name:	Preferred Name: Preferred Gender Identity:  Home street address:  City: Preferred phone #: e-r	Administrative Sex:  Mal	le 🗆 Female
Home street address:  City:  Preferred phone #:  Calls or e-mail will be discreet, but please indicate any restrictions:  Voicemail OK  Power of Attorney or Responsible Party (if applicable):  Relationship to Client: Home street address:  City:  State: Zip:  Preferred phone #:  Calls or e-mail will be discreet, but please indicate any restrictions:  Voicemail OK  Text Messages OK  Preferred phone #:  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 #  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	Home street address: City: e-r	 State: Zip: mail:	
City:	City: e-r	State: Zip: mail:	
City:	City: e-r	State: Zip: 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 #: 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			
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Relationship to Client:	□ Voicemail OK □ Text Messages OK		
Home street address:	Power of Attorney or Responsible Party (if applicable):		
City: State: Zip: Preferred phone #: e-mail: Calls or e-mail will be discreet, but please indicate any restrictions: U voicemail OK	Relationship to Client:		
Preferred phone #:e-mail:	Home street address:		
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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	□ Private Pay - Responsible Party:		
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Referral: Who gave you my name to call?  Name:  May I have your permission to thank this person for the referral? □ Yes □ No	•		
Name: May I have your permission to thank this person for the referral? □ Yes □ No	Name of Insured (Policy Owner)	Insured's DOB:	
May I have your permission to thank this person for the referral? ☐ Yes ☐ No			
	May I have your permission to thank this person for the refer	ral? □ Yes □ No	
Religious and racial/ethnic identification	Religious and racial/ethnic identification		
•	_	Catholic □ .lewish □ Islamic □ F	Buddhist 🗆 Hindu
Carron rongicus donomination annual a rotostant a outrone a sewich a islamic a buddhist a rink	Other (specify):		
Other (specify):	Involvement: ☐ None ☐ Some/irregular ☐ Active		
	How important are spiritual concerns in your life?		

**Client Information Form** 

Which (if any) church, synagogue, temple, or meeting	ng 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 ge		
Facility/doctor's name:		):
Address: If you enter treatment with me, may I tell your medic	al doctor so that he or she can he	fully informed and we can
coordinate your treatment? ☐ Yes ☐ No	al doctor so that he of she can be	rully illionned and we can
coordinate your treatment: 1 res 11 No		
Important medical information (Including allergies):		
Your goals for art therapy treatment:		
Daine a manian a cuith and		
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	?	

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