DSM __________
(Office Use Only)

Ilyssa Swartout, Psy. D.

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(602)980-9313

Client Information

Date of First Appointment: ____________ **Referred by:** _______________________

Personal Information (All areas marked with a * MUST be completed)

Client Name: _____________________________________ **Nickname:** ___________
First *MI* *Last*
*Home Address:

____
Street *City* *State* *Zip*
*Client's E-mail Address: ____________________@____________
Client's Home Phone #: (_______) ____________________________
Client's Business Phone #: (_______) _____________________________
*Client's Main Cell Phone #: (_______) _____________________________
Other Important Phone #: (_______) _____________ *Type of #? ___________
* Client's Social Security #: _______ -________ -_________
* Client's Date of Birth: ______ /______ /______ Age: __________
* Client's Gender (choose one): Female Male
* Client's Martial Status (choose one): Single Married Other (Other includes Divorced, Widowed & Domestic Partnerships)
* Client's *School OR Work Status (choose only one): F/T Student P/T Student OR Employed Not Employed*

Emergency Contact Information (All areas marked with a * MUST be completed)

*Name: __________________________ *Relationship to client: ____________
* Contact Phone #1: (_______) _____________________________
* Contact Phone #2: (_______) _____________________________
*Emergency Address:

____
Street *City* *State* *Zip*

If you live outside of Arizona, please provide a local emergency mental health crisis line phone number in your area:

____

To (re) schedule appointments your therapist will call the numbers listed on page 1.

May therapist leave a message on an answering machine? *Yes___ No___*
May therapist leave a message with someone at these numbers? *Yes___ No___*
May therapist leave an email message? *Yes___ No___*

How did you hear about us? (choose one)

Insurance Co *Friend* *Client of ours* *GoodTherapy.org* *Dex Online*

Psychology Today Website *Yellow Pages (book)*

Google Search Words ___________________ Which brought you to ______________________

Doctor __________________________________
Name

Other Person who referred you ____________________________

APPOINTMENT CANCELATION POLICY: Growing Edges LLC requires that cancellations for scheduled appointments be received 24 hours in advance. Unkept or cancelled appointments that do not follow this policy will be charged an unkept appointment fee at the discretion of your therapist. This fee can equal but will not exceed the therapist fee for the time originally scheduled.

If you miss or cancel an appointment in less than 24 hours from the time of your scheduled appointment, or arrive for an appointment on the wrong day or time, you will be responsible for paying for that session. If I cancel an appointment in less than 24 hours of your scheduled time, or if I have put you in my schedule at the wrong time, then your next session is free.

I have read and understand the above stated policy of Growing Edges LLC.

____ _________________________
Signature of Responsible Party (required): **Date**