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Los Angeles, CA 90064

Confidential Client Information

Date____________________

Name________________________________ Birth Date______________

Street Address__________________________________

City___________________________________

Home Phone_________________ Cell____________________

Email______________________

Work Phone_______________________

Employer____

Work Address____
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Physician Name____________________________ Phone ___________________

Psychiatrist Name__________________________ Phone___________________

Current Medications___________________________ Dose_________________

In Case of Emergency Notify____

Phone____________________________ Relationship____________________

I authorize Sharon Schwartz, Ph.D to release or exchange pertinent clinical information regarding myself to/with____

Signature_______________________________ Date_____________________

Signature_______________________________ Date_____________________

Guardian Signature (if minor)________________________ Date____________