Tara J. Louchery, PsyD

CLIENT INFORMATION SHEET

LAST NAME_____FIRST_____

ADDRESS _____CITY_____STATE_____
ZIP_____

BIRTHDATE ____/____/_____

EMAIL ADDRESS _____

PRIMARY PHONE # _____Msg OK? Y / N Text OK Y / N
ALTERNATIVE PHONE # _____Msg OK? Y / N Text OK Y / N

EMERGENCY CONTACT NAME _____
RELATIONSHIP_____ PHONE#_____

OCCUPATION _____
EMPLOYER_____

PRIMARY PHYSICIAN _____
PHONE # _____

Name preferred to be called: _____
Gender Identity: _____
Preferred Pronouns: _____

INSURANCE PLAN: _____ ---*or*---- Self Pay Rate _____