



JENNIFER BALLERINI, PSY.D

Helping People Build Better Relationships

CLIENT INFORMATION

Name: _____ Birthdate: _____

Address: _____

Phone: _____ Email: _____

Current Medications/Medical Problems: _____

Names of All Previous Counselors Seen & Approximate Start/End Dates: _____

Reasons for Seeking Treatment: _____

How did you find out about our practice?

_____ Google Search _____ Referred by Friend _____ Referred by Physician/Therapist

_____ Other: _____