Cina Hoey, LCSW

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516.477.9774

Client Information

Name: ____ Date of Birth: ________________

Age: ______ Marital Status: Single ☐ Married ☐ Separated ☐ Engaged ☐ Divorced ☐ Widowed ☐

Address: ____

City: ______________________________________ State: ___________________ Zip Code: ______________

Phone Number: ________________________________ Is it okay to leave a message? Yes ☐ No ☐

Email Address: ____

Primary Care Doctor: ________________________________ Psychiatrist: ____________________________

Current Medications: ____

Current Medical Conditions: ____

Have you had any previous mental health treatment, counseling, or therapy? Yes ☐ No ☐

Employer: ____ Occupation: _______________________________

Emergency Contact Person: _____________________________________ Phone: _______________________

How did you find this practice? ____

Fee per session: ______________

Signature: ____ Today's Date: ______________________

(Signature of Patient/Parent if Minor)