Callia Zimmerman LICSW LADC
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callia@calliazimmerman.com

CLIENT INFORMATION

First name

Last name

Middle name

Preferred Name

Birth date (MM/DD/YYYY)

Gender

ADDRESS

Address, City, State, Zip

EMAIL

Email address

❒ OK to send email

❒ Send me email reminders for appointment

PHONE

Phone type	Phone number
❒ Cell	
❒ Home	
❒ Work	

❒ OK to leave a voice message

❒ OK to send text message

❒ Send me text message reminders for appointment

Who is your primary care physician? (Please include type of provider, name and phone number):

Specify all medications and supplements you are presently taking and for what reason.

Level of education (highest grade/degree and type of degree):

Current occupation and employer:

EMERGENCY CONTACT

First Name

Last Name

Relationship

Phone Number

Insurance

Insurance Company	
Group ID	
Plan ID	
Member ID	

Client's relationship to insured: ❍ Self ❍ Client's spouse ❍ Client's parent ❍ Other