PORTLAND DIALECTICAL BEHAVIOR THERAPY PROGRAM, PC
5200 SW MACADAM AVENUE, STE 580 PORTLAND, OREGON 97239

PHONE: (503) 231-7854 **FAX: (503) 231-8153**

CLIENT INFORMATION SHEET

Client Name_______________________________________ DOB__________S.S. #____________________
Age________ Gender ___________ Relationship Status________________ Sexual Orientation_________________________
Home Address____ City____________________ State____ Zip_____________
Home Phone________________________ Cell Phone____________________ Can we leave a message? _____yes _____no
Driver's License #___________________

Job Title____ Employer____
Work Address____
Work Phone _________________________ Can we leave a message? _____yes _____no

Students: Grade _________ School__________________________ School Counselor_______________________________
Address____Phone________________________

If child or teen:
Legal Guardian Name____ DOB __________S.S. # ___________________
Relationship to client: Parent ____Other____ (check one) If other, specify relationship____________________________
Address____
Phone (home) ____________________________________ (work)____

Emergency contact____ Relationship__________________________________
Address____
Phone (home) ____________________________________ (work)____

☐ No Primary Physician
Primary Physician____ Date of last visit________________________
Address____Phone________________________________

☐ No Psychiatric Prescriber
Psychiatric Prescriber ____ Date of last visit________________________
Address ____ Phone________________________________

Who referred you to this office? ____
Address____Phone________________________________

Reasons for referral?____
____
____

Client or authorized person's signature: I authorize the Portland DBT Program to make contact with the referral source and my physician for purposes of treatment planning and coordination of care.

____ ____________________________
Signature Date