

Mark Zentner, Ph.D.
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Austin, TX 78757
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Confidential Client Information

Date: _____

Name: _____

Street Address: _____

City/State/ZIP: _____

Home Phone: _____ Cell phone: _____

Occupation: _____ Employer: _____

Gender: _____ Date of Birth: _____ Age: _____ Relationship Status: _____

Ethnic/Racial Background: _____

Insurance Company: _____ Group/Policy Number: _____

Individual Insurance Policy Number: _____

Name of physician: _____

If you have previously participated in mental health treatment, please describe reason(s) for seeking treatment at that time, when treatment began, duration of treatment, and whether or not you felt it was helpful: _____

Describe any current health concerns: _____

List medications you currently take:

Please briefly describe the concern(s) which led you to begin therapy at this time:
