Westchester Trauma Recovery Network
EMDR Humanitarian Assistance Program

Client Information

Identification

Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____

Home Address:_____ Apt.:_____

City:_____ State:_____ Zip:_____

Home Phone Number:_____ Mobile Phone Number:_____

Calls will be discrete, but please indicate any restrictions:_____

_____

We would like to check in with you a couple of times after we have worked together to see how you are, and ask some follow-up questions. What is the best way to contact you to set up a time to talk?

_____

_____

How did you learn about us? _____

Other Professionals Involved in Your Treatment - ☐ *(check if s/he has No Health Care Providers)*

Medical Provider/Clinic Name:_____

Address:_____ Phone:_____

May I have your permission to contact this person for continuity of care? ☐ Yes ☐ No

Psychiatric Provider/Clinic Name:_____

Address:_____ Phone:_____

May I have your permission to contact this person for continuity of care? ☐ Yes ☐ No

Emergency Contact

If there is an emergency during our work together, or I become concerned about your personal safety, I am required by law and the rules of my profession to contact someone close to you (relative, spouse, close friend).

Name:_____ Relationship to you:_____

Phone number(s):_____