Johanna R. Rayman, LCSW, GCFP - Independent Practitioner
1611 NE 16th Ave · Portland, OR 97232 · 503-380-5437

CLIENT INFORMATION Today's date _____

Date of birth _____ Gender: for insurance- _____ identity/ pronouns- _____

Legal Name (to use with insurance) _____

Preferred Name (if different) _____

Street Address _____

City _____ State _____ Zip _____

Phone

1_____ ☐primary number ☐ok to leave msg ☐ok to text*

2_____ ☐primary number ☐ok to leave msg ☐ok to text*

Would you like to receive appointment reminders by text? ☐Yes ☐ No

Email address*: _____

**Please note that texting and email will not be used for therapeutic interactions.*

Who referred you? _____

EMERGENCY CONTACT / PARTNER / GUARDIAN

Who should I contact in an emergency? _____

Relationship to client _____

Phone: 1_____ 2_____ 3_____

In the case of an emergency, I consent for my therapist to contact the person listed above.

_____ _____
Signature Date

OTHER EMERGENCY INFORMATION

Primary Care Physician _____

Clinic _____ Phone_____

Allergies or medical alerts: _____

_____

Any other medical information you feel I should know in an emergency: _____

_____

_____

OTHER INFORMATION

If there is information you would rather let me know about in writing, please use the back of this page. Thank you!