Client Information

Date: _____

Name: _____

Address: _____

Phone: Home:_____ May I leave a message?:_____
Work:_____ May I leave a message?:_____
Alternate:_____ May I leave a message?:_____

Date of Birth:_____ Social Security Number:_____

Marital Status: Single Married Divorced Separated Widowed

Employer/School:_____ Highest Level of Education:_____

Referred by:_____

Party Guaranteeing Payment for Services (This can NOT be a third party payer)
Name:_____
Address (if different from above):_____
_____
Phone (if different from above):_____

Emergency Contact Person/Next of Kin:_____
Address (if different from above):_____
_____
Phone (if different from above): _____

List all of the people who live in your household (Not including yourself):

Name	Relationship	Gender	Age

List current health conditions:

_____
_____
_____

List current medications:

_____
_____
_____

Reasons for seeking counseling at this time:

_____
_____
_____

List any other professional involvement (psychiatrist, physician, attorney, court involvement):

_____
_____
_____

How do you intend to pay for services?

Cash_____
Check_____
Credit_____

I understand that payment for therapy services is expected at the time services are rendered.

A 5% charge is added to credit card use.

There is a $30 fee for returned checks.

_____ Date:_____
Client's signature

_____
Parent/guardian's signature