CLIENT INFORMATION

(Please Print Clearly)

Client Name:____

Last First

Date of Birth: ________________________________

(MM/DD/YYYY) Age

Address:____

City State Zip

Email Address (Please write clearly): ________________________________

I wish to be contacted in the following manner (***INITIAL*** all that may apply):

______ Home Telephone:____________________

______ O.K. to leave a message with detailed information

______ Leave message with call-back number only

______ Work/Cell Phone: _______________

______ O.K. to leave a message with detailed information

______ Leave message with call-back number only

Names of others within the family that may also participate in family therapy (I confirm that I am the legal guardian of anyone under the age of 18 who will participate in therapy services, or I have and can provide proof of consent of the legal guardian):

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

FINANCIAL RESPONSIBILITY (please fill out if other than primary client)

Name:____

Last First Relationship

Address:____

City State Zip

Phone:______________________ ______________________ ________________

Home Work Mobile

I accept full responsibility for all fees due to professional services. I understand that 48 hours notice is required to cancel or change an appointment and that if 48 hours notice is not given, I am responsible to pay a cancellation charge of $75.00. I understand that third and subsequent late cancellations will be billed the full session fee. Additionally, I am responsible for payment of all services provided noted in the signed consent for treatment form.

Signature of Responsible Party: __________________________ Date:_______________

IN CASE OF EMERGENCY

Name: ____

Last First Relationship

Phone:____

Home Work Mobile

REASON FOR COUNSELING:

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WHAT DO YOU HOPE TO ACHIEVE FROM COUNSELING:

____

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How did you hear about the practice?____

If online what website or search words did you use? ___________________________________

Were you referred? Circle YES or NO If so, who referred you?_____________________

Have you ever received psychiatric or psychological help or counseling of any kind? If so, please explain:

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MEDICATIONS/SUPPLEMENTS/BOTANICAL MEDICINE:

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____

MEDICAL CONDITIONS:

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