



EVOLVE
MindBody
Wellness

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):

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone: _____ | <input type="checkbox"/> Work Telephone: _____ |
| <input type="checkbox"/> O.K. to leave a message with detailed information | <input type="checkbox"/> O.K. to leave a message with detailed information |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> 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 \$50.00. 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:

WHAT DO YOU HOPE TO ACHIEVE FROM COUNSELING:

How did you hear about us? _____

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:

MEDICATIONS/SUPPLEMENTS/BOTANICAL MEDICINE:

MEDICAL CONDITIONS:
