

Client Information

Date _____

Your Name _____ Date of Birth _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email address _____

Ok to call you and/or leave messages at home? ___yes___no

Employer/School _____

Relationship Status _____

Please list only those family members who live with you.

Family Member's Name	Relationship	Age	Occupation/School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Person who can be contacted in case of emergency? Name _____

Address _____ Phone _____

What brings you here? _____

Prior counseling? ___yes___no When and with whom _____

Lisa Blair, MA process-oriented facilitator

For what issues? _____

Current medical or physical issues? _____

Current medications (list all including dosage) _____

Do you drink alcohol? ___yes___no

How Often? _____ How much? _____

Do you use other substances? ___yes___no

How Often? _____ How much? _____

Physician's name _____

Address _____ Phone _____

How did you hear about my services? _____

Who referred you? _____ May they be thanked for the referral? ___yes___no

Please read the above information carefully and sign to confirm that you understand and agree to it:

Signature _____ Date _____