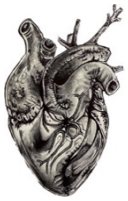

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Therapy & Consulting

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CLIENT INFORMATION

Date: _____

Name: _____

Address:_____

_____

Phone: _____

Email: _____

Date of Birth: _____

Age: _____

Driver's License:_____

Social Security Number: _____

Occupation:_____

Employer: _____

Emergency Contact: _____

_____

If I am using insurance, the provider and policy number are: _____

_____

I was referred by: _____

I am taking medications:
☐ No ☐ Yes, name and dosage: _____

_____

I have done therapy before:
☐ No ☐ Yes, when and length of time: _____

The outcomes of participating in therapy were: _____

_____