



Client Contact Information

Client's Name: _____ Age: _____ Gender: ___ M ___ F ___ Other _____

Race/Ethnicity: _____ Date of Birth: _____

Adult's Name (if client is a minor) _____

Employer: _____ Occupation: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

(circle all numbers above at which you give permission to be contacted)

Okay to leave a voicemail? yes ___ no ___

E-mail address(es): _____

May we add you to our monthly newsletter mailing list? Yes ___ No ___

Health Insurance information: Name of insurance _____

Phone number# _____ Policy and/or Member # _____

Group _____ List the preferred way(s) for therapist to reach you _____

Person(s) to Contact in Case of an Emergency:

1. Name _____ Relationship to you _____

Best way to contact this person _____

2. Name _____ Relationship to you _____

Best way to contact this person _____

I realize that there is a possibility that I may compromise the level of confidentiality when using cell phones and e-mail to communicate. Please indicate by placing your initials next to each means of communication to which you give your consent to use: E-mail ___ Cell phone ___ Cell voicemail ___ (please refrain from texting therapist except in the case of communicating scheduling changes)

I also realize that the contact numbers for the therapists are cell phone numbers _____

Client Signature _____ Date: _____

Parent Signature (if client is a minor) _____ Date: _____

Parent Signature (if dual custody of child) _____ Date: _____