

Client Information Form

(Please print all but your signature. Thank you!!)

Client Name: _____ Date of First Visit: _____

Date of Birth _____ Age _____ Marital Status _____

Sexual Orientation (optional): _____

Home Address: _____
Street City State Zip

Home Phone (_____) _____ Cell Phone (_____) _____

Can I leave a **message**? ___yes; ___no. Can I **identify myself** & my profession? ___yes; ___no.

Can I send you **text messages (via cell phone)** regarding scheduling or appt times? ___yes; ___no.

E-mail _____ Fax(_____) _____

Can I use your **e-mail** regarding appointments and/or sending financial information? ___yes; ___no.

Employer: _____ Job Title: _____

Work Phone: (_____) _____ Can I leave a **message** on work phone? ___yes; ___no.

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Address: _____

Phone Number: (_____) _____ Other Number: (_____) _____

By including this person's name & phone number, you are authorizing me to contact this person should you suffer an emergency while at my place of business, or if I am unable to reach you for extended periods of time. It is important, for your safety, to include a name and phone number, at the very least.

Should an emergency situation arise outside of my normal business hours, please call & leave a message on my business phone. I will respond within 24 hours. If your need is more urgent, please call 9-1-1 or go immediately to the nearest emergency room.

Reasons for Referral/Symptoms: _____

Who referred you to this office? _____

Address: _____

Phone: (_____) _____

"I have read this form and agree to the terms. I have also read and agree to the terms stated in the Professional Disclosure Statement. By signing this form, I authorize Kimberly Christiansen, LPC, CADC III to make contact with the referral source to thank him/her and let him/her know contact has been made."

Signature: _____ Date Signed: _____