CLIENT INFORMATION

DATE	REFERRED BY		
YOUR NAME: FIRST	**MIDDLE**	**LAST**	
ADRESS: STREET	**CITY**	**STATE**	**ZIP CODE**
HOME PHONE	**CELL/WORK PHONE (BEST)**	**E-MAIL**	

MAY WE CONTACT YOU AT THE ABOVE NUMBERS/E-MAIL ADDRESS?

WHO SHARES YOUR HOME? Include names and ages of all family members:

EMPLOYER	OCCUPATION/TITLE		
SOCIAL SECURITY NUMBER --- ----	**BIRTHDATE**	**AGE**	**MARITAL STATUS**

EMERGENCY CONTACT

NAME	RELATIONSHIP	PHONE NUMBER

Are you currently receiving psychiatric services or psychotherapy elsewhere? ☐Yes ☐No

Have you had previous psychological counseling? ☐Yes ☐No

Are you currently taking prescribed psychiatric medication (antidepressants or others)? ☐Yes ☐No

If no, have you ever, at any time been previously prescribed psychiatric medication? ☐Yes ☐No

Have you or any member of your family been hospitalized for psychiatric reasons? ☐Yes ☐No

I understand that I am responsible for all fees owed to Barbi Pecenco Kolski, LMFT for professional services rendered. I also understand that any fees for appointment not cancelled within 24 hours of scheduled appointment time will be my responsibility. Further, all charges are expected to be paid at the time services are rendered. I also understand and waive my right to confidentiality if a collection service or court action is needed to collect on a delinquent account.

Signature of Responsible Party: ___________________________________ Date:_________________