

Primary Client: _____ Gender: _____ Age: _____

Date of Birth: _____ Current/Highest Level of Education: _____

If client is a minor, who is the legal guardian? _____

Copy of custody order or guardianship provided (if applicable): YES NO

FAMILY INFORMATION

Parent: _____ Age: _____

Parent: _____ Age: _____

Other family _____ Relationship: _____ Age _____

members or: _____ Relationship: _____ Age _____

people living: _____ Relationship: _____ Age _____

in home: _____ Relationship _____ Age _____

CLIENT (OR PARENT) INFORMATION:

Primary address: _____ Home Phone: _____

Cell Phone: _____

Employer: _____ Occupation: _____

Work Phone: _____

Email address: _____ Other Phone: _____

OK to contact you at numbers listed? Yes No: _____

How were you referred? _____ May I thank them? YES NO

CURRENT MEDICATIONS/MEDICAL PROBLEMS OF PRIMARY CLIENT

PAST OR CURRENT COUNSELING/THERAPEUTIC SERVICES OF PRIMARY CLIENT

AUTHORIZATION AND ACKNOWLEDGEMENT OF INFORMED CONSENT

____ I certify that the above information is correct, assume responsibility for payment of services (including those not paid by my insurance carrier), and I authorize Cindi Bockwitz to provide counseling/therapeutic services to (check one or both) _____ me _____ and/or to my child ____ I have received/read the Office Policies & Procedures/ Disclosure Statement.

Signature: _____ Date: _____