

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 members or: _____	Relationship: _____	Age: _____	
people in home _____	Relationship: _____	Age: _____	

CLIENT (OR PARENT/GUARDIAN) INFORMATION	
Primary address: _____	Home Phone: _____
_____	Cell Phone: _____
Employer: _____	Occupation: _____
_____	Work Phone: _____
Email address: _____	Other Phone: _____
OK to contact you at numbers listed? ___ Yes ___ No (list): _____	
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 DISCLOSURE STATEMENT/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 Disclosure Statement/Informed Consent form.

Signature: _____ Date: _____

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