**Client Information Demographics**

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| Name (First, Middle Initial, Last): What pronouns do you use? Birthdate (mm/dd/yyyy) |
| Street Address: |  | City: State: Zip Code: |
| Preferred Phone: |  | May we leave a message?  YES NO  |
| Social Security Number: |  | Preferred Email Address:May we email you? YES NO |
| Employer: Full-time Part-time | Marital Status: S M W D |
| Education Level (highest grade completed): | Student Now? School:Yes No |
| Have you (patient) had previous counseling? Yes No | If yes, please tell us when and with whom: |
| Emergency Contact (name, relationship, phone): | Initial here for permission to contact in case of emergency |
| How did you hear about us: |  |

**Parent I Legal Guardian Information** (for patients under 19yrs of age, elderly, mentally disabled, etc)

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| Parent/Guardian Name (First, Middle Initial, Last): | Relationship to Patient: |
| Street Address: | City: |  State: Zip: |
| Home Phone: Work Phone: | Ceil Phone: |
| Parent/Guardian Name (First. Middle Initial, Last): | Relationship to Patient: |
| Street Address: | City: |  State: Zip: |
| Home Phone: Work Phone: | Cell Phone: |