NEW CLIENT FORM (Adult)

Date:_____

Name: _____ Partner's Name: _____

Age: _____ Date of Birth: _____ Age: _____ Date of Birth: _____

Mailing Address: _____

E-mail _____ E-mail_____

Phone #s:Hm _____ Wk_____ Cell_____ Phone #s: Hm_____ Wk_____ Cell_____

Occupation: _____ Occupation: _____

Employer: _____ Employer: _____

Relationship Status: Married___ Committed___ Single___ Divorced___ Separated___ Widowed___

Years in Current Relationship: _____

Dates of Previous Marriage(s)/Committed Relationships: _____

Children	Age	Grade in School
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician: Yours_____ Partners_____

Date of last physical: Yours _____ Partners_____

Current Medications: _____

Previous Therapist(s) Seen, When, By Whom:

_____

_____

Emergency Contact: _____ Relationship: _____

Phone: _____