Connections Counseling Services

Client Information

Name: ____

Referral Source: ☐ Internet Search ☐ Family/Friend ☐ Religious Leader

☐ Other: ____________________________

Age: _______ Date of Birth: ______________ Intake Date: ________________

Address: ____

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Home Phone: ______________________ Message OK? Yes No

Work Phone: ______________________ Message OK? Yes No

Cell Phone: ______________________ Message OK? Yes No

Email: ____

With whom do you live?

Name: ______________________________ Knowledge of therapy? Yes No

Message OK? Yes No

Name: ______________________________ Knowledge of therapy? Yes No

Message OK? Yes No

Name: ______________________________ Knowledge of therapy? Yes No

Message OK? Yes No

Name: ______________________________ Knowledge of therapy? Yes No

Message OK? Yes No

Name: ______________________________ Knowledge of therapy? Yes No

Message OK? Yes No

In case of emergency, notify:

Name: ____

Phone: __________________________ Relationship to patient: ____________________