



LIFE COACHING & COUNSELING CENTERS

CLIENT INFORMATION FORM

Name of Client: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell: _____ Pager: _____

Social Security #: _____ Date of Birth: _____ Male Female

Single Married Separated Divorced Widowed Child

Referral Source: Previous Client Physician Pastor Advertising

Other (please specify) _____

Briefly state the nature of the presenting problem: _____

For purposes of coordination of care, please answer the following:

Name of primary care physician: _____

Names of other regularly treating physicians (psychiatrist, counselors, etc.): _____

May we have permission to contact them? Yes No