

CLIENT DATA FORM - CONFIDENTIAL

**1** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Name(s) of other individual(s) attending therapy with you: \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Have you been in therapy before? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Occupation: \_\_\_\_\_ School/University \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ (May I leave a message on this number?)  Yes  No  
 Work Phone: \_\_\_\_\_  Yes  No Cell: \_\_\_\_\_  Yes  No  
 E-mail: \_\_\_\_\_

**2** **How did you hear about me?**  General internet search  Magellan directory  
 The Family & Marriage Counseling Directory (www.family-marriage-counseling.com)  
 National Registry of Marriage Friendly Therapists (www.marriagefriendlytherapists.com)  
 National Directory of Marriage and Family Counseling (www.counsel-search.com)  
 Google ad  
 Personal recommendation (name) \_\_\_\_\_  
 Professional referral: (name) \_\_\_\_\_  
 Psychology Today  News/media  Other: \_\_\_\_\_

**3** **Emergency Contact Person:** \_\_\_\_\_  
 Phone (home/cell): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Relationship \_\_\_\_\_

I give permission for Ms. Suppes to contact this individual in case of an emergency.

\_\_\_\_\_  
Signature of Client Date

**4** **Person to be named on therapy billing statement (only needed if other than yourself):**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 (Print address below if this person is not attending therapy with you)

**5** **Are you seeing another therapist or psychiatrist currently? Yes \_\_\_\_\_ No \_\_\_\_\_**

Names: \_\_\_\_\_  
 (Please fill out Release of Information form and will discuss with you if it is necessary for me to coordinate treatment)