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 (students): _____

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 □ Aetna 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 (not regular Google search results, ads appear on the right side of your search results)

□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 Thorner 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___

Name(s): _____

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

6

Would you like a FREE subscription to *Compass*, my bi-monthly e-newsletter (6 issues per year) that gives you ideas and tips about emotional intelligence, relationship fitness and mind/body health? (You can easily unsubscribe at any time).

Yes ___ No___

OFFICE USE ONLY

DIAGNOSIS:	**OPENED:**
BASIC FEE:	**CLOSED:**

Authorization for Care

I, the undersigned, have received and read the Client-Clinician Agreement provided by Laurie Thorner, LCSW-C, and I authorize him to provide the services of psychotherapy and/or counseling to me.

I understand that the psychotherapy/counseling services provided to me are by appointment only and may not be available on an emergency basis.

I am aware of the cancellation policy and know that I will be charged for a full session if I miss an appointment or cancel within 24 hours notice.

_____ _____
Printed Name Date

_____
Signature

_____ _____
Printed Name (partner or family member) Date

_____
Signature

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