Presence of Mind
INTEGRATIVE HEALING
SUSAN HAYES, LPC

CLIENT INFORMATION

Date: _____

Client Name: _____ DOB: _____

Address: _____

City/State/Zip: _____

Phone: Home: _____Cell:_____ Work: _____

Email Address: _____
Emergency Contact: _____ Phone: _____
Relationship Status: _____
Children? If yes, names and ages: _____
_____
Employer: _____
Address: _____

Referred By: _____
Insurance Company: _____ Policy #: _____
Physician: _____ Phone: _____
Insured's name_____ Date of Birth:_____
Current medications: _____
_____
History of medical problems: _____
_____
Have you been in therapy before? Y N When: _____
Briefly describe your experience: _____
_____
_____
What brings you to therapy now? _____
_____
_____
What would you like to accomplish? _____
_____

Client Signature: _____Date: _____

Parent/Guardian Signature: _____Date: _____