now & **NEXT** counseling

1 SALO DRIVE, TRUMANSBURG, NY 14886
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TODAY'S DATE: ___/___/___

CLIENT'S NAME:_____Date of birth: ___/___/___

Name you prefer to be called:_____Preferred pronouns:_____

Grade & School -OR- Occupation: _____

Address:_____

Client cell phone:_____

Client email address:_____

Parent or guardian (if applicable):_____

Parent/guardian phones (if applicable):_____

Parent/guardian email (if applicable):_____

Reason for seeking counseling:_____

_____

EMERGENCY CONTACT

Name:_____

Address:_____

Phone:_____Relationship:_____

PEOPLE IN HOUSEHOLD(S), NAMES, AGES, OCCUPATIONS, & RELATIONSHIP TO CLIENT:

_____

_____

COUNSELING HISTORY:_____

_____

_____

IMPORTANT MEDICAL HISTORY:_____

_____

_____

PRIMARY CARE DOCTOR:_____LOCATION:_____

CURRENT MEDICATIONS DOSAGE PRESCRIBER

_____

_____

_____

HEALTH INSURANCE COMPANY_____

ANYTHING ELSE YOU WOULD LIKE ME TO KNOW ABOUT YOU OR YOUR FAMILY:_____

_____

_____

ARE YOU INTERESTED IN HAVING A THERAPY DOG AT COUNSELING SESSIONS? YES/NO

HOW DID YOU HEAR ABOUT THIS COUNSELING PRACTICE?
_____ FRIEND _____ OTHER THERAPIST _____PSYCHOTHERAPY TODAY WEBSITE
_____ GOOGLE _____ FACEBOOK _____OTHER (PLEASE LIST): _____