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. Levine 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)

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)

5

Would you like an email subscription to *Love Good Be Well*, a monthly newsletter on the topic of emotional intelligence, relationship fitness and mind/body health? (You can easily unsubscribe at any time).

Yes ___ No___

Authorization for Care

I, the undersigned, have received and read the Agreement for Psychotherapy Services provided by Beth Levine LCSW-C, and I authorize her to provide psychotherapy/counseling to me.

I understand that the psychotherapy 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.

______________________	______________________	__________
CLIENT SIGNATURE	PRINTED NAME	DATE
______________________	______________________	__________
CLIENT SIGNATURE	PRINTED NAME	DATE
______________________	______________________	__________
CLIENT SIGNATURE	PRINTED NAME	DATE
______________________	______________________	__________
Beth Levine LCSW-C	PRINTED NAME	DATE