



LifeMenders
Counseling

CLIENT INTAKE FORM

(Please Print)

Today's Date _____

Therapist _____

CLIENT INFORMATION

Client's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Ms.		Marital Status (C@& One) Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former Name)		Birth Date	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	ZIP Code	Social Security	Home Phone No.	
P.O. Box		City	State	ZIP Code	Cell Phone No.		
Occupation	Employer				Work Phone No.		
Referred to LifeMenders by (Please check one box & list)				<input type="checkbox"/> Dr. _____	<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Website
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to Home/Work		<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other _____		
Email Address:				Alternative Email Address:			

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Client	Home Phone No.	Work Phone No.

PLEASE READ THE FOLLOWING CAREFULLY

I understand that I am responsible for my fee payment at the beginning of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.

CLIENT/GUARDIAN SIGNATURE _____

DATE _____

I hereby consent to treatment recommended by the LifeMenders therapist. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestions, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

X _____

CLIENT/GUARDIAN SIGNATURE

DATE