CLIENT INTAKE FORM

Today's Date: ___/___/_____ **Therapist: Colleen Tredway, MA, LMHC**

Client's Last Name	First	Middle	❑Mr. ❑Ms. ❑Miss.

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date ___/___/_____	Age	Sex ❑Female ❑Male

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 Provider by (Please check one box/list) ❑Doctor. ❑Website ❑ ❑Family ❑Friend
❑Home/Work ❑Yellow Pages ❑ Other: _____

Email Address:	Alternative Email Address:

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

In case of an Emergency Please Contact:_____

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.

I understand that I am responsible for any balance due prior to a decision to stop.

_____ _____/_____/_____
CLIENT/GUARDIAN SIGNATURE DATE

_____ _____/_____/_____
CLIENT/GUARDIAN SIGNATURE DATE