Marsh-Knickle & Associates

NEW CLIENT INFORMATION FORM

Name (please print): _____ **Age:** _____ **Date of Birth:** _____ **Sex: M F**

(If applicable) School: _____ **Grade:** _____

Cell Phone: _____ **May we leave a message at this number? (please circle one) YES NO**
Voicemail ☐ Person:_____
Home Phone: _____ **May we leave a message at this number? (please circle one) YES NO**
Voicemail ☐ Person:_____
Work Phone: _____ **May we leave a message at this number? (please circle one) YES NO**
Voicemail ☐ Person:_____
Email: _____ **May we contact you via email? (please circle one) YES NO**

Address (Parent/Guardian) # [1]: _____**City/Town:** _____ **Postal Code:**_____

Address (Parent/Guardian) #[2]: _____**City/Town:** _____ **Postal Code:**_____

Emergency Contact: _____ **Cell Phone:** _____ **Other:** _____

Are you currently, or likely to be, involved in a lawsuit? (please circle one) YES NO

What do you want to work on in counselling?_____

Any previous experience with counselling? If so, why?_____
_____

Who referred you to us? _____ **Phone:** _____

Name of your family doctor: _____ **Phone:** _____

Please list any current illnesses/medical conditions: _____
_____

**** Please list all the people who currently live with you:**
(if client resides at more than one address please indicate information for both)

	First name:	Last Name:	Age:	Relation to you:
Address #1				
Address #2				

Insurance Company to which you plan to submit receipts, if applicable: _____

Do we have your permission to share information about your therapy with the following person(s), in order to facilitate services that are being provided to you?

The referral source named above: (please circle one) YES NO
The family doctor named above: (please circle one) YES NO

***Please note:** The client or an authorized representative, may rescind or amend the authorization in writing at any time prior to the expiration, except where action has been taken in reliance on the authorization.

_____ _____

Signature **Date**