FairView Counseling and The Play Therapy Center Client Information Form

Today's Date: ____________________ Client# ___________

Name of Person Completing this Form:______________________________________
(if other than client)

Phone Number(s) that we may call you:
Home: __________________ Work: _________________ Cell: ___________________

Client's Name: ____ Sex: M F

Age: ____ DOB: _____/_____/_____ Social Security# __________________________

Address: ____
(street address) (city) (state) (zip)

Marital Status of Client: Single Married Separated Divorced Widowed (circle one)

Client's Employer/School: ____

Address of Employer/School: ____

Name of Client's Primary Care Physician:_____________________________________

Address: ____
(street address) (city) (state) (zip)

Name of Person Responsible for Payment: _____________________________________

If Client is a Minor:
Mother's Name: ____

Mother's Address: ____

Father's Name: ____

Father's Address: ____

How did you hear about FairView Counseling? _________________________________

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Throughout the year, FairView Counseling sends announcements of events, group and a newsletter to the community. Would you like to be on our mailing list? YES NO

12/06 SJH