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 (students): _____

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

Emergency Contact Person: _____
Phone (home/cell): _____
Address: _____
Relationship _____
I give permission for Ruth Berger to contact this individual in case of an emergency.

_____ _____
Signature of Client Date

3

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)

4

Are you seeing another therapist or psychiatrist currently? Yes ___ No___

Name(s): _____
(Please fill out *Release of Information* form and I will discuss with you if it is necessary for me to coordinate treatment)

5

***This is not required for your treatment and is entirely optional.* As a professional courtesy, Ruth Berger would like to contact your general practice physician. Many doctors appreciate knowing one of their patients is starting psychotherapy, for the purposes of follow-up with you, if appropriate, about the quality of care you receive from me.**

_____ _____
Name of General Practice Physician: Phone #:

I (circle one) DO / DO NOT give Ruth Berger permission to inform the physician named above *only* that I am engaged in psychotherapy with you. (A separate release of information is needed if you want to give your therapist full permission to release specific details of your treatment to your physician.)

6

Would you like a FREE subscription to *Compass*, Keith Miller Counseling's bi-monthly e-newsletter (6 issues per year) that gives you ideas and tips about emotional intelligence, relationship fitness and mind/body health? (You can easily unsubscribe at any time).

Yes ___ No___

7

If you were personally referred to us, are you able to share that person's name?

Personal Recommendation From: _____

Authorization for Care

☐ I, the undersigned, have received and read the Client-Clinician Agreement provided by Ruth Berger, and I authorize her to provide the services of psychotherapy and/or counseling to me.

I understand that the psychotherapy/counseling 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.

_____ _____

Printed Name Date

_____

Signature

_____ _____

Printed Name (partner or family member) Date

_____

Signature