Cressan Smith, LPC

Client Contact Information

Name: _____ **DOB:** _____ **Age:** ____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years of age):

_____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number) (City) (State) (Zip)

Home Phone: _____ **Cell:** _____

E-mail: _____

Permission to be contacted by therapist at (please check all that apply):
___ Home OK to leave a message? ___ yes ___ no
___ Cell OK to leave a message? ___ yes ___ no
___ Text (Texting is **NOT** considered a **confidential** medium of communication.)
___ E-mail (Email is **NOT** considered a **confidential** medium of communication.)

Preferred means of being contacted: ___ Home ___ Cell ___ Text ___ E-mail

What brought you here today? _____

Referred by: _____ May I contact them to thank them? _____

Emergency Contact: _____

Phone: _____ **Relationship to you:** _____

Client/Parent Signature: _____ **Date:** _____