Client Information

Name________________________

Date of Birth__________________Age___________________SS#_____________________

Marital Status_______________________Sexual Orientation_________________________

Home Address____

Home Phone # ____

May I leave a message? ___________yes___________No

Cell #____

May I leave a message _______________yes_________No

Email: _______________________________(Please note that email may not be confidential)

Emergency Contact___________________________Relationship_____________________

Phone Number____

Primary Care Physician______________________________date of last visit_____________

Address____

Phone #____

Employer____

Student/School____ Grade____________

Phone #____

Who referred you to my office?_____________________________Phone________________

Brief reason for referral:

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Client or authorized person's signature: I authorize Li Lin Hally, LCSW to make contact with the referral source and/or Primary Care Physician for purposes of treatment planning and coordination of care.

____________________________________ ____________________________________

Signature Date

____________________________ ____________________________ ______________

If minor, Signature of Legal Guardian Printed Name Date