CLIENT DATA SHEET

DATE: _____

Client Name: _____
Preferred Pronoun: _____

Policy No.	Insurance Company:
Street Address:	Apt. No.
City, State, Zip:	Parish/County:
Phone: _____ Permission to Leave messages? Y/N	Email: _____ Permission to send emails? (will contain consent forms/worksheets, not personal therapy notes). Y/N
Date of Birth:	Marital Status: In a relationship? Y/N

Race/Ethnicity:	Gender:	Religious Pref.:	Sexual Pref:

Referral Source Name and Contact Info:

Relationship of Referral Source:

Emergency Contact 1: Name: _____

Phone: _____ Relationship: _____

Emergency Contact 2: Name: _____

Phone: _____ Relationship: _____

Preferred Times: Weekdays/Weekends Mornings Afternoons Evenings Anytime

Primary Care Physician: _____ Date of Last Visit: _____

Primary Care Phone: _____ (Will not contact without your written consent)

Preferred Sessions: Online Phone Your Home Other Location

Current Student: Y/N Last Grade Completed:

Occupation: On Disability?

Have you ever received therapy before? Y/N

How did you hear about Dallas M Counseling?

Preferred Method of Payment: Cash Venmo Zelle Paypal

Client Signature: _____ Date: _____

Print Name: _____

Staff Signature: _____ Credentials: _____

Print Name: _____

Date: _____