CLIENT'S APPLICATION FOR SERVICE

CLIENT INFORMATION

NAME:_____ DATE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

DATE OF BIRTH:_____

HOME PHONE NUMBER:_____

WORK #_____ CELL #_____

E-MAIL ADDRESS:_____

MARITAL STATUS/SPOUSE'S NAME:_____

PARENTS AND/OR GUARDIANS' NAME AND ADDRESSES (as applicable):

_____ _____
_____ _____
_____ _____

PREVIOUS COUNSELING, THERAPY, OR PSYCHIATRIC TREATMENT:

_____
_____
_____

MEDICAL PROBLEMS:_____
CURRENT MEDICATIONS:_____
ALLERGIES:_____
PHYSICIAN:_____ DATE OF LAST PHYSICAL:_____

CONSENT FOR TREATMENT

I voluntarily consent to participate in mental health and/or substance abuse services with Denise Breinig-Glunz, MSW, LCSW.

Signature_____ Date:_____
(Adolescent 15 to 17 must sign with parent cosign)

Signature_____ Date:_____
(Parent or Guardian if a minor)