Counseling Services of Arizona
Heidi Quinlan LPC, LISAC

Adult Client Information Form

Identification of Client

Today's Date:_____

Client Name: _____ Birth Date:_____ Age: _____
Client Soc. Sec. #:____/____/_____ Nick Name:_____ Male:_____ Female_____
Address: _____ City: _____ Zip: _____
Can we send billing statements and other correspondence to this address? **Y / N** (*circle one)* If not, Where?
_____

I wish to be contacted in the following manner: (Initial all that apply)

_____ Home Telephone: _____ _____ Cell Telephone: _____

_____ O.K. to leave a message with detailed info _____ O.K. to leave a message with detailed info

_____ O.K. to contact or respond via text message _____ O.K. to contact or respond via text message

_____ Leave message with call-back number only _____ Leave message with call-back number only

_____ OK to be contacted through email. If so, please provide your email address: _____

Employment Status: ___ Unemployed ___Employed ___Full-time Student ___Part-time Student ___Full-time Parent
Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed No. of Marriages: _____

Person's Living in Household

Name	Relationship	D.O.B.	Employer/School

Emergency Information
In case of emergency, contact:
Name:_____ Relationship:_____
Phone:_____ Alternative Phone: _____

Medical Care: Please fill in all Information. Keep therapist updated on any medical or medication changes.

Doctor's Name: _____ Phone: _____
Address: _____ City:_____ Zip:_____
List all medications currently taken:_____
_____
List any Psychiatric medications taken:_____
_____
I may ask to consult with your medical doctor so that he/she can be fully informed and we can coordinate your treatment if necessary? Y / N (Circle One)
Authorization For Treatment:
Client Signature: _____ Date: _____