

LifeSpring Center

Mission Valley • Carlsbad • Rancho Bernardo
Phone (619) 298-8722 • Fax (619) 298-5235

INITIAL INFORMATION

Welcome to our office. Please read and complete these pages. Your therapist will come to the waiting room to meet you.

Name _____ Social Security # _____ Date of Birth _____

Spouse's Name _____ Social Security # _____ Date of Birth _____

Address _____ City _____ State/Zip _____

Employer _____ Position _____ Work Phone _____

Home Phone _____ Best Time to Call _____ Email Address _____

Marital Status _____ Date of Present Marriage _____

Church Affiliation (if applicable) _____

Children's Names & Ages _____

Who lives at your home _____

What is the major relationship issue or situation for which you wish counseling _____

What counseling have you had previously _____

What medications, if any, are you now taking _____

Person to notify in case of emergency _____

Address _____ City _____ State/Zip _____

Phone # _____ Relationship to you _____

Who Referred You _____ May we thank them for referring you? Yes _____ / No _____

Your therapist may _____ / may not _____ send you email regarding upcoming conferences and seminars.

Your therapist may _____ / may not _____ identify him/herself when he/she calls your work.

Your therapist may _____ / may not _____ identify him/herself when he/she calls your home.

Date _____ Client Signature _____