

PATHWAYS COUNSELING CENTER

CLIENT INFORMATION

(page two)

Client's Name: _____

Referred by: _____

Primary Care Physician: _____ Phone: _____

NOTE: Pathways Counseling Center will not relay any information to your PCP unless requested by you in writing.

Have you seen another therapist or psychiatrist this year? Yes No When? _____

If yes, name of other therapist or psychiatrist: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

HOME PHONE

CELL PHONE

WORK PHONE EXT. #

MINOR CLIENTS

(17 years old or under)

Biological Mother: _____

FULL NAME

HOME PHONE

CELL PHONE

WORK PHONE

Biological Father: _____

FULL NAME

HOME PHONE

CELL PHONE

WORK PHONE

Please list all other adult family members that are active in the child's life (ex: step or grandparent):

NAME RELATIONSHIP BEST PHONE NUMBER

NAME RELATIONSHIP BEST PHONE NUMBER

NAME RELATIONSHIP BEST PHONE NUMBER

NAME RELATIONSHIP BEST PHONE NUMBER

NAME RELATIONSHIP BEST PHONE NUMBER

Please list clients' siblings:

Name: _____ Age _____ Name: _____ Age _____

Name: _____ Age _____ Name: _____ Age _____

Name: _____ Age _____ Name: _____ Age _____