

**CONFIDENTIAL CLIENT INFORMATION FORM/COUPLES**

**Colleen Russell, LMFT, LPC, CGP**  
**Licensed Marriage and Family Therapist (MFC29249); Certified Group Psychotherapist (41715)**  
**San Francisco Bay Area, Marin County, California**  
**Phone: 415-785-3513; email: crussellmft@earthlink.net**

Name(s): \_\_\_\_\_

Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State: \_\_\_\_\_

Dates of Birth : \_\_\_\_\_ ; \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_ ; \_\_\_\_\_

Email Addresses: \_\_\_\_\_  
\_\_\_\_\_

Emergency Person and Number to Call: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Previous/Current Psychotherapy or Counseling**

For Whom? \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_ Therapist(s) Name(s) \_\_\_\_\_

For Whom? \_\_\_\_\_ From: \_\_\_\_\_ To: \_\_\_\_\_ Therapist(s) Name(s) \_\_\_\_\_

Medical Information: ( Physical Conditions; Past and Current Medications and dosages):  
\_\_\_\_\_  
\_\_\_\_\_

Married, Year \_\_\_\_\_ Partnership, Year \_\_\_\_\_ Divorced , Year \_\_\_\_\_

How Long in Current Relationship? \_\_\_\_\_

**Occupation and Position or Current Enrollment in School:**

Current: \_\_\_\_\_ ; Past: \_\_\_\_\_

Current: \_\_\_\_\_ ; Past: \_\_\_\_\_

Highest Education: \_\_\_\_\_ Degree: \_\_\_\_ Subject: \_\_\_\_\_

Highest Education: \_\_\_\_\_ Degree: \_\_\_\_ Subject: \_\_\_\_\_

What deaths or major losses have you experienced? \_\_\_\_\_

---

Do you have any medical insurance? Yes \_\_\_\_ No \_\_\_\_

Name of Insurance: \_\_\_\_\_ Member Number: \_\_\_\_\_

Self-Pay Agreement: You attest that you (Please circle) a) do not have insurance coverage, b) have insurance coverage but choose not to use it, and understand that in so doing you are waiving any right to reimbursement; or c) have insurance coverage, but understand that counseling or psychotherapy services provided by Colleen Russell, LMFT, are not covered by the plan. If not a provider, you may provide a statement to your insurance company for out of network coverage. Initial: \_\_\_\_\_ Initial: \_\_\_\_\_

Fee: We have agreed on a fee of \_\_\_\_\_ per hour .

What brings you to therapy?

---

---

---

---

---

---

---

---

Signature: Client and Date

---

Signature: Client and Date