**CLIENT INFORMATON FORM/FORMER MEMBER**

**Colleen Russell, LMFT , CGP**
**Licensed Marriage and Family Therapist (MFC29249); Certified Group Psychotherapist (41715)**
**Phone: 415-785-3513; email: crussellmft@earthlink.net**

Name: _____ Date: _____

Street Address:_____

City, State: _____

Date of Birth: _____

Telephone: (H) : _____(W): _____ (Cell): _____Email: _____

Emergency Person Name, Relationship, Number to Call:
_____

Referred By: _____

Previous/Current Psychotherapy or Counseling From: _____To: _____Therapist(s)' Name(s)

_____

Medical Information: ( Past and Current Medications and dosages, Conditions):
_____
_____
_____

Single ___Married/When?__ ___Partnership ___Divorced /When? _____Bereaved/When?____ ___

Children/Age _____

_____

How Long in Current Relationship? _____Partner's Name: _____

What group(s) were you involved in? _____

How long? _____When did you leave? _____

Occupation and Position or Current Enrollment in School:
Currrent_____

Past & Year (s) _____

Highest Education: _____Degree: ____ Subject: _____

Insurance: _____Member Number_____

Self-Pay Agreement: You attest that you understand that counseling, consultation, or psychotherapy services provided by Colleen Russell, LMFT, CGP, may be covered as an out of network provider if you have health insurance, but payment is due at the time of services through cash, check, or credit card. Yes, I attest: _____

Fee: We have agreed on a fee of _____Individual _____Group

What brings you to therapy now?

_____

_____

_____

_____

Signature: Client