

CONFIDENTIAL CLIENT INFORMATION FORM/LOSS

Colleen Russell, LMFT, CGP
Licensed Marriage and Family Therapist (MFC29249)
Certified Group Psychotherapist (41715)
San Francisco Bay Area
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Name: _____ Date: _____

Street Address: _____

City, State: _____

Date of Birth: _____

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

Emergency Person, Number to Call, Relationship:

Deceased:

Name: _____ Relationship to me: _____

Date of Death: _____ Age: _____ Cause of Death: _____

About the Family: (List all living in the home)

Name	Age:	Relationship:

Medical Information: (Past and Current Medications, Conditions)

Single ___ Married ___ Partnership ___ Divorced ___ When ___ Bereaved ___ When _____

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

What other significant losses have you experienced and when?

Current Functioning (Please include eating/sleeping patterns, changes in peer/family interactions, physical concerns, etc.) _____

Occupation and Position or Current Enrollment in School:

Highest Education: _____ Degree: _____ Subject: _____

Do you have any medical insurance? Yes _____ No _____

Name of Insurance: _____

Self-Pay Agreement: You attest that you a)do not have insurance coverage (please check) _____, b)have insurance coverage but choose not to use it, and understand that in so doing you are waiving any right to reimbursement (please check) _____; or c) have insurance coverage, but understand that counseling or psychotherapy services provided by Colleen Russell, LMFT, CGP, are not covered by the plan (please check)_____.

Referred By: _____

Previous/Current Psychotherapy or Counseling From: _____ To: _____ Therapist(s)' Name(s)

Fee: We have agreed on a fee of _____

What brings you to therapy or counseling?

Signature: Client

Signature: Therapist