CONFIDENTIAL CLIENT INFORMATION FORM/MOTHERLESS DAUGHTER

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

Name: ____Date:___________

Street Address:____

City, State: ____

Date of Birth: ___________________________

Telephone: (H) : _____________(W): ______________ (Cell): _________________

Email: ____

Emergency Person and Number to Call: ______________________________________

Referred By: __________________ Previous/Current Psychotherapy or Counseling From:
___________To: __________Therapist(s)' Name(s) _____________________________
____

Medical Information: (Past and Current Medications, Conditions)
____
____

Single ___Married ___Partnership ___Divorced ___When ___Bereaved ___When ________

How Long in Current Relationship? _________Partner's Name: ______________________

When did you lose your mother, through death or other circumstance? __________________

How old were you at the time? _____

What was the cause of your mother's death , illness, separation, or estrangement?____

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)______.

Fee: We have agreed on a fee of _______________________________________

What brings you to therapy or counseling?
____
____
____

_______________________________________ _________________________________

Signature: Client Signature: Therapist