CONFIDENTIAL CLIENT INFORMATION FORM

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

Names and Date of Birth of Each Family Member Involved in Counseling:

_____

_____

_____

_____

Date of First Session: _____

Street Address:_____

City, State: _____

Telephone Numbers: :_____; _____

_____; _____; _____

Email(s)_____

_____

_____

Emergency Person, Number, Name, Relationship to Call:
_____

Referred By: _____

Parents or Partners: ___Married ___Partnership ___ Step-Parent: _____
Divorced___When ___Bereaved ___When ___

Previous Marriage for : _____Date Divorced or
Separated: _____Reason: _____
_____
Previous Marriage for: _____Date Divorced or
Separated: _____Reason: _____
_____

How Long Parents/Partners in Current Relationship? _____

Occupation and Position of Parent(s):

_____

_____

School, Grade of Minor:

_____

Physician: _____City: _____

Psychiatrist: _____

Medical Information of each Family Member, Current Medications:

_____

Significant losses the family has experienced and when:

_____

What brings you to therapy or counseling?

_____

_____

_____