

**CLIENT INFORMATION**

**Geoff Steurer, MS,LMFT**

First Name Last Name Date

Address City State Zip Code

Home Phone Office Phone Mobile Phone

Email Address \_\_\_\_\_

Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Male \_\_\_\_ Female \_\_\_\_

Single \_\_\_\_ Married \_\_\_\_ Other \_\_\_\_

Employed \_\_\_\_ Full-time Student \_\_\_\_ Part-time Student \_\_\_\_ Other \_\_\_\_

Family Doctor Name/Phone \_\_\_\_\_

Who referred you? \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name \_\_\_\_\_ Phone \_\_\_\_\_

**PERSON RESPONSIBLE FOR PAYMENT**

If client is responsible for bills there is no need to re-enter information here, otherwise complete this section.

Title First Name Last Name

Address City State Zip Code

Home Phone Business Phone

Relationship to client \_\_\_\_\_

**FAMILY INFORMATION**

Name of Spouse \_\_\_\_\_ DOB \_\_\_\_\_

If a minor, name of parent(s) or guardian(s):

Children of an adult, or siblings of a child client, and/or others living at home:(if more than 4 list on back)

First Name Last Name DOB In Home?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_