

CLIENT INFORMATION – Children and Family

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Today's date _____

Child's Name _____

Age _____ Birthdate _____ School/Grade _____

Home address _____ City _____ Zip _____

Phone: Home _____ Child's cell _____

Other contact #'s _____

Contact e-mail _____

Childs's e-mail _____

Preferred mode of communication _____

Names, ages and & relations of people in the home _____

Reason for coming to counseling _____

Pediatrician contact information

Doctor's name:

Phone #

Current medication _____ for _____

Referred by _____

Do I have your permission to acknowledge the referral? _____

Other information you would like me to know (about you, your child or your family):

GUARDIAN(S) INFORMATION

If guardians' addresses, phone numbers, etc. are different, please include both sets of information—thank you

Name(s) _____

Age(s) _____ / _____ Birth date(s) _____ / _____

Home Address _____

City _____ Zip _____

Second Residence: _____

Parent's contact phone #'s _____

E-mails

Please let me know if you do not want to be contacted or have messages left at any of the above.

Occupation (s) _____

Relationship status _____

Name(s) of financially responsible party _____

Relationship to client _____