CLIENT INFORMATION

Leslie Foge, MA, LMFT Psychotherapy Services

Bruce Sorenson, MA, Associate MFT (#120604)

Employed & Supervised by Leslie Foge (MFC#23841)
954 Risa Road Suite A
Lafayette, CA 94549
925 -323- 7126
brucesorensontherapy@gmail.com

Today's date_____

Name(s) _____

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

Home Address:_____

City _____Zip_____

Phone: Home _____Work _____

Cell (s)_____

E-mail(s) _____

_____

Preferred mode of
communication_____

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

Occupation _____

Relationship
status_____

Spiritual or Religious Affiliation _____

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

_____

Client Information

Reason for coming to counseling

_____

_____

Current medication(s) _____ for_____

Prescribed by _____

Referred by _____

Do I have your permission to acknowledge the referral? _____

Other information you would like me to know about you or your family?

_____

_____

Please fill out below if someone else is financially responsible for therapy.

Name(s) of financially responsible party _____

Relationship to client _____

Street Address:_____

City/State _____ Zip _____

Phone: Home _____Work _____

E-mail_____