TERRI PHILLIPS
Marriage and Family Therapist Inc
909-730-0410 www.terriphillipsmft.com

CLIENT INFORMATION FORM

Date: _____

Client Name: _____ Date of Birth: _____
Address: _____ City _____ State _____ Zip _____
May I mail to you this address? Yes_____ No_____ May I e-mail you? Yes___ No___
Email: _____
Social Security #: _____

Home Phone: _____ Work Phone: _____
Cell Phone: _____
Occupation _____ How long in this occupation? _____
Who lives with you? _____
_____

Emergency Contact Name: _____
Phone Number: _____

Who were you referred by: _____
May I contact this person to thank them: Yes: _____ No: _____

Previous Counseling and/or Psychiatric Treatment:
(Please include name of provider, length and focus of treatment)
_____
_____
_____
_____

Medications (Please include dosages if known):
_____

Significant Health Problems: _____

What you hope to gain in counseling:
_____
_____
_____

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FOR CLIENTS 18 AND YOUNGER:

Legal Guardian Name: _____
Address: _____ City _____ State _____ Zip _____

Social Security #:_____

School: _____ Grade: _____

Emergency Contact Name: _____
Phone Number: _____

Medications (Please include dosages if known):
_____
_____

What you hope to accomplish in counseling:
_____
_____
_____
_____

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32605 Temecula Pkwy #208 909-730-0410
Temecula, CA 92592