Client Information Sheet

Date of first appointment _____

Client name _____

Date of birth _____

Address _____

_____

Parent/s names _____ _____

Parent/s emails _____ _____

Parent work # _____ _____

Parent cell # _____ _____

Client email _____

Home phone # _____

Cell phone # _____

School and grade _____

Psychiatrist name and # _____

Present medications _____

_____

Referred by _____

Are you interested in... ☐ Individual/Family therapy ☐ Group therapy

Would you like statements mailed to you for insurance purposes? ◯ Yes ◯ No

Cancellation Policy

Please note that I have a 24-hour cancellation policy. Appointments cancelled or broken for non-emergency reasons with less than 24 hours' notice will be billed at full fee.

Please sign and date to indicate that you have read and agree with the above policy.

_____ _____

Signature Date