Steamboat Springs Therapy LLC

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Client Information

Name: _____ Referred by: _____ Date:_____

Address: _____Email: _____

Phone (circle the best #): Home: _____Work: _____ Cell: _____

OK to contact you at all given numbers? ___ Yes ___ No May I thank referral source? ____ Yes ____ No

Date of Birth: _____

Couple's Therapy

Partner's Name: _____ Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Email: _____OK to call you at all given numbers? ____ Yes ____ No

Date of Birth: _____

Family Therapy

List all the family members who live in your home:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____