FAMILY PINNACLE, LLC
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NEW CLIENT INFORMATION

NAME _____DATE_____

ST. ADDRESS _____CITY_____ ST_____ ZIP_____

HOME PHONE ( )_____ CELL PHONE ( ) _____

WORK NUMBER ( ) _____ MARITAL STATUS _____

OCCUPATION _____DOB_____YRS. EDUCATED_____

If the client is a minor, please list the name, address and relationship of the responsible parent/guardian:

NAME _____RELATIONSHIP _____

ST. ADDRESS _____CITY_____ST_____ZIP_____

HOME PHONE ( ) _____ CELL PHONE ( )_____

WORK ( )_____ REFERRED BY_____

PRIMARY CARE PHYSICIAN _____ PHONE NO. ( )_____

Please describe your problem or reason for the referral:

_____

_____

Please describe any prior psychological services:

_____

_____

OTHER FAMILY OR MEMBERS OF HOUSEHOLD

NAME AGE RELATIONSHIP

_____

_____

_____

_____

I understand that any services I receive are to be held confidential by my therapist and Family Pinnacle, LLC unless I authorize the release of specific information in writing. I understand that this is my right and that my therapist is obligated to protect this on my behalf except under certain circumstances. I understand that a therapist-client relationship exists between myself (or child) and a psychologist affiliated with this practice. I assume final responsibility for all financial obligations associated with any services I receive and that the final responsibility does not fall upon my insurance company or other third party. Payment for services is due at the time of services unless other arrangements are made.

_____ _____

Signature Date