Hope Crossing Christian Counseling, Inc.

Client Name:_____________________________________ Preferred Name:______________
Last, First, MI

Social Security Number:_______-_____-_______ Date of Birth____/____/____ M__ F__

Address:____ Apt. Number:________
Street Number , Street

____
City , State, Zip

Phone Numbers:(_____)_____-_________ (_____)_____-_________ (_____)_____-________
(circle type of contact) Primary Daytime Contact: H C W Secondary Contact: H C W Alternate Contact: H C W

E-Mail Address:_______________________________________ Okay to send emails? Y N

Marital Status: (circle one) Single Married Separated Divorced Widowed

Ethnicity: White African-American Asian Hispanic American-Indian Other_______

Employer Name:__________________________________ Occupation__________________
(Circle One) Full Time Part Time

School Name:__________________________________ Grade________ Full Time/Part Time

(If Dependent Child; are custodial parents: (Circle One) Married Divorced Separated Other

Emergency Contact:____
Name Relationship

(_____)_____-________ ____
Phone Address City State Zip

Primary Care Physician:______________________________________(_____)_____-_______
Name Phone Number

Psychiatrist (If Applicable):__________________________________ (_____)_____-_______
Name Phone Number

Financially Responsible Party (Guarantor)____
Name

Relationship to Client: (Circle One) Self Spouse Parent/Guardian Other

If Different From Client:

(_____)_____-_________ ____
PhoneAddress Address City State Zip

Social Security Number:_______-_____-_______ Date of Birth____/____/____ M__ F__

Signed:____Date:____/____/____