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CONFIDENTIAL CLIENT INFORMATION

PLEASE TAKE A MOMENT TO READ THROUGH AND FILL OUT THE FOLLOWING:

Date: _____

Name _____

Address _____

City / State / Zip _____ May I contact you at this address? _____

Home Phone _____ Alternate Phone _____

Occupation _____ Employer _____

Sex _____ Date of Birth _____ Age _____ Marital Status _____

Ethnic Background _____

Name(s) of previous therapist(s) and dates seen: _____

Describe any health concerns: _____

List drugs/medications you presently use: _____

Referred by: _____ Phone _____

Emergency Contact: I require that you give me contact information for a person I can contact in case of emergency and it is to your benefit to do so. This contact will only be used if I believe you or someone else is in immediate danger or if you become ill and unable to continue or depart therapy without assistance.

Emergency Contact's Name: _____ Relationship: _____

Address: _____

Phone Number: _____

Please initial your agreement for me to contact the above named person under the above named conditions. _____

