CONFIDENTIAL CLIENT INFORMATION FORM/MOTHERLESS DAUGHTER

Colleen Russell, LMFT, CGP
Licensed Marriage and Family Therapist (MFC29249)
Certified Group Psychotherapist (41715)
San Francisco Bay Area
Phone: 415-785-3513; email: crussellmft@earthlink.net

Name: _____Date:_____

Street Address:_____

City, State: _____

Date of Birth: _____

Telephone: (H) : _____(W): _____ (Cell): _____

Email: _____

Emergency Person and Number to Call: _____

Referred By: _____ Previous/Current Psychotherapy or Counseling From: _____To: _____Therapist(s)' Name(s) _____
_____

Medical Information: (Past and Current Medications, Conditions)
_____
_____

Single ___Married ___Partnership ___Divorced ___When ___Bereaved ___When _____

How Long in Current Relationship? _____Partner's Name: _____

When did you lose your mother, through death or other circumstance? _____

How old were you at the time? _____

What was the cause of your mother's death , illness, separation, or estrangement?_____

What other significant losses have you experienced and when?
_____
_____
_____

Current Functioning (Please include eating/sleeping patterns, changes in peer/family interactions, physical concerns, etc.) _____
_____
_____
_____

Occupation and Position or Current Enrollment in School:
_____
Highest Education: _____Degree: _____ Subject: _____

Do you have any medical insurance? Yes _____ No _____

Name of Insurance: _____

Self-Pay Agreement: You attest that you a)do not have insurance coverage (please check) ____, b)have insurance coverage but choose not to use it, and understand that in so doing you are waiving any right to reimbursement (please check) _____; or c) have insurance coverage, but understand that counseling or psychotherapy services provided by Colleen Russell, LMFT, CGP, are not covered by the plan (please check)_____.

Fee: We have agreed on a fee of _____

What brings you to therapy or counseling?
_____
_____
_____

_____ _____
Signature: Client Signature: Therapist