Client Information

Emergency Contact: ***Name***_____

Phone _____ ***Relationship*** _____

MORNING LIGHT COUNSELING

Client Name:	Date of birth:	SS#:
Occupation: Employer:	Current Medical Conditions:	
Gender: Male ____ Female ____ Marital status:	Current Medications:	

Spouse / Parent Information:

Name:	Date of birth:	SS #:
Occupation: Employer:	Current Medical Conditions:	
Gender: Male ____ Female ____ Marital status:	Current Medications:	

Family Information : Children

Name_____ **Age** _____ **Lives w/ you? Y/N**	**Name**_____ **Age** _____ **Lives w/ you? Y/N**
Name_____ **Age** _____ **Lives w/ you? Y/N**	**Name**_____ **Age** _____ **Lives w/ you Y/N**
Name_____ **Age** _____ **Lives w/ you? Y/N**	**Name**_____ **Age** _____ **Lives w/ you? Y/N**
Name_____ **Age** _____ **Lives w/ you? Y/N**	**Name**_____ **Age** _____ **Lives w/ you? Y/N**

Other Family Members Seen Here:

Name/s:	**Relationship:**

Why You are Seeking Help At This Time:

Your Goals and Hopes for Counseling:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Morning Light Counseling or insurance company to release any information required to process my claims.

Patient / Guardian Signature _____ ***Date :***_____