Sarah Eisinger, LMFT

CLIENT REGISTRATION

(PLEASE PRINT) Today's Date: ___/___/___

Client's full name: -
_____

Home Address: _____City: _____ State/Zip: _____

Home Phone: _____ Cell Phone: _____

Age: _____Date of Birth: _____

Client's Employer: _____ Phone: _____

Full Name of Spouse: _____ Date of Birth: _____

Student (y/n): _____ Name of School: _____

Family Physician: _____ Referred by: _____

Other Mental Health Professionals you have seen: _____

_____

List Medications & Reason Prescribed: _____

_____

Emergency Contact _____ Relationship to Client _____

Home/Cell Phone_____

Reason for seeking therapy