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McArthur Counseling Center 2025

New Client Information Sheet

Please Print Clearly

CLIENT: **Date**:_____

Legal Name:_____
First MI Last

Street Address: _____
Street Address CAN NOT be PO Box City State Zip

Mailing Address: _____
City State Zip

Birth date: _____**M / F** **SSN:** _____--_____--_____

(H) Phone: _____ **(C) Phone:** _____

E-Mail:_____

Employer: _____**Position:**_____

Family / Personal Physician :_____**Location:**_____
Pharmacy Name:_____**Location:** _____

Emergency Contact:_____**Phone#:**_____

Marital Status: Single Married Divorced Separated Widowed

PARENT: (if minor) or SPOUSE (if married)

Name:_____
First MI Last

Address: _____

Birth date: _____ **SSN:** _____--_____--_____

(H) Phone: _____ **(C) Phone:** _____

Employer: _____ **Position:** _____

For what reason(s) are you seeking counseling at this time? _____
_____
_____

Referred by:_____