Penny J. Fife, MFT, CEDS

Confidential Client Information

SECTION 1 – PERSONAL INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: _____

E-Mail: _____

Home Address:_____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____

Marital Status: Married Separated Divorced Never Married Widowed

Spouse's Name: _____ Spouse's Cell Phone: _____

Who referred you to our office? _____

SECTION 2 – EMERGENCY CONTACT INFORMATION

List the name of a person that we may contact in case of emergency. *(Not living with you.)*

Name: _____ Relationship: _____Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

SECTION 3 – GENERAL INFORMATION

List present and previous health problems: _____

_____

List medications you are currently taking: _____

_____

List agencies, persons or other professional resources where you have obtained service for emotional, social, family or personal concerns:

_____

List your goals concerning counseling at this time: _____

_____

Children: Name	**Age**	**Lives at Home**	**Health Problems**

I do hereby give my consent for my treatment to Penny J. Fife, MFT, CEDS

Signature: _____ **Printed Name:** _____ **Date:** _____