LETY ARREOLA-GARCIA, AMFT#94052

CLIENT INFORMATION FORM

Name _____ Date of Birth ____/____/____

Age _____ Relationship Status _____ Number: _____

Home address (city, state, zip code):

_____

Please list your phone numbers and check next to the number(s) where you prefer to be contacted:

☐Home phone (____)_____ Message may be left at this number:Yes☐ No☐

☐ Work phone (____)_____ Message may be left at this number: Yes ☐ No☐

☐ Cell phone (____)_____ Message may be left at this number: Yes ☐ No ☐

Email Address:_____

Have you previously been seen for mental health treatment? Yes ☐ No ☐

If yes, please list the provider(s), treatment(s), duration(s):

_____

_____

_____

How were you referred to my practice?

_____

_____ _____/_____/_____

SIGNATURE DA TE

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http://corazóncounseling.com
Supervised by Carolyn Moore, LCSW#26169, (415) 423-1930