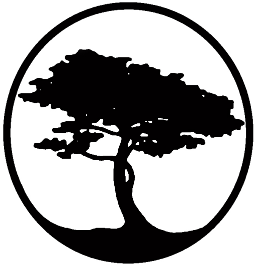

Center for Transpersonal Therapy, LC

Denise Boelens, Ph.D.
Wil Dredge, L.C.S.W.
Heidi Gordon, L.C.S.W.
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Nick Tsandes, L.C.S.W.
Sherry Lynn Zemlick, Ph.D.

The Center for Transpersonal Therapy is a limited liability company which includes licensed therapists, professional counselors and programs that share a common Transpersonal perspective. To economize our time together, please supply the following information and **read and sign** the accompanying service contract.

Client Name:____Date:____________________________

Address:____Zip:_____________________

Home Phone: ____________________Work Phone: ___________________ Cell Phone: ________________

Social Security #: _________________________________Birthdate: ________________________________

Name of School: ____Grade:_____________________

Father's Name: ____Father's Birthdate: _________________

Home Phone: ___________________Work Phone: ____________________Cell Phone: _________________

Address (if different): ____Zip:______________

E-mail address:____

Occupation:_______________________________Employer:_______________________________________

Mother's Name: ____Mother's Birthdate: ________________

Address (if different):____Zip: _______________

Home Phone: ___________________Work Phone: __________________ Cell Phone: __________________

E-mail address:____

Occupation: ______________________________Employer:______________________________________

If parents are divorced, who is the custodial parent? (relevant divorce papers must be provided) ____________
____

Name, address, and telephone number of nearest relative not living with you: __________________________
____

In case of emergency, name, address and telephone number of a person we may call: ______________________

____

Please list the members of your present household:

Name Age Relationship Occupation

____

____

____

____

____

Name, address and telephone number of your Primary Care physician and/or Child's Pediatrician:

____

____

____

Briefly describe your reason for seeking help. ____

____

____

____

Who suggested you contact us?____

How would you describe your physical health at this time?_________________________________

____

____

Please list any medications you (the client) are taking at this time, their dosage, the reason they're prescribed and the prescribing physician and phone number:

Medication Dosage Reason Prescribed Physician Phone

____

____

____

____

Have you ever received psychiatric or psychological help of any kind before? ________________

If you have, please briefly explain: ____

____

____

____

Who will be responsible for payment: ____

Address: ____

Phone: ____________________________________Relationship to client: __________________________