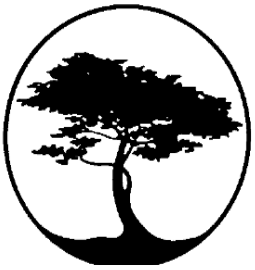

CENTER *for* TRANSPERSONAL THERAPY, LC

Denise M. Boelens, Ph.D.
Wil Dredge, L.C.S.W.
Heidi Ford, L.C.S.W.
Chris Robertson, L.C.S.W.
Lynda Steele, L.C.S.W.
Sherry Lynn Zemlick, Ph.D.
Nick Tsandes, L.C.S.W.

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, would you 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 # _____ Birth Date _____

Name of School _____ Grade _____

Father's Name:_____ Father's Birth Date_____

Home Phone _____Work Phone_____Cell Phone _____

Address (if different)_____

E-mail Address_____

Mother's Name:_____Mother's Birth Date_____

Home Phone _____Work Phone_____Cell Phone _____

Address (if different)_____

E-mail Address_____

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

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

_____

In case of emergency, the 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? _____

_____

_____

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

_____

If you have, would you briefly explain?

_____

_____

_____

_____

Please list any medications you (the client) are taking at this time with their dosage:

_____

_____

Who will be responsible for payments? _____

Address_____

Phone_____ Relationship to you _____

PERMISSION TO CONSULT

It may be helpful for your therapist to discuss aspects of counseling with other CTT Clinical/Consulting members, for the purposes of consultation and/or supervision. Your confidentiality will be safeguarded, and relevant information will only be discussed with trained and qualified personnel on the Clinical/Consulting team who may be able to help your therapist provide you with the best possible service. We are asking your permission to have this option.

I, _____hereby give permission to my therapist to consult with qualified Clinical personnel as the need arises. I understand that this permission is in effect from the date below until our work is complete, or until I withdraw my permission.

Signature _____ Date _____