Center *for* Transpersonal Therapy, LC

Denise M. Boelens, Ph.D.
Wil Dredge, L.C.S.W.
Heidi Gordon, L.C.S.W.
Chris Robertson, L.C.S.W.
Kate Tolsma, L.C.S.W.
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, **read and sign** the accompanying service contract.

Client Name: _____ Date: _____

Address: _____ Zip: _____

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

Social Security #: _____ Birthdate: _____

Email address: _____ Employer: _____

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

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 medication you (the client) are taking at this time, their dosage, and reason prescribed and 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 you: _____

PERMISSION TO CONSULT

It may be helpful to 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 in writing.

Signature: _____ Date: _____