Center *for* Transpersonal Therapy, LC

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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: _____

Name of School: _____ Grade: _____

Father's Name: _____ Father's Birthdate: _____

Address (if different): _____ Zip: _____

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

Email address: _____

Occupation: _____ Employer: _____

Mother's Name: _____ Mother's Birthdate: _____

Address (if different): _____ Zip: _____

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

Email address: _____

Occupation: _____ Employer: _____

If parent's 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?

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 client: _____