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: ______________________

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: ______________________