COUNSELING OFFICE OF PAUL K. HERSH MFT, PSY.D.

Client Information Sheet

First Name _____ MI _____ Last _____

Address _____

City _____ St _____ Zip Code _____

Home: (_____) _____ Business: (_____) _____

Cell: (_____) _____

Birthday _____ SS# _____ *

Marital Status: ☐ married ☐ single ☐ divorced ☐ widowed

Spouse Name _____ Age _____

Child's Name _____ Age _____

Child's Name _____ Age _____

Child's Name _____ Age _____

Child's Name _____ Age _____

Referred By _____

Emergency Contact Person _____

Phone: (_____) _____ Relationship _____

Medical Doctor: _____

Phone: (_____) _____ Last Visit _____

Medications: _____

_____

Additional Information: _____

_____

* Only needed if seeking insurance reimbursement.