LIGHTHOUSE
COUNSELING CENTER
Start a Brighter Path

Counseling I am seeking: ❒Individual ❒Couple ❒Family ❒Group Counseling

CLIENT INFO

Date of Birth:____/______/_______

Name: ____

Address: ____

City:_____________________________ Zip: _____________

Home #___________________Cell #____________________

Work #___________________Other #___________________

On what number may we leave a confidential message:

❒Home ❒Cell ❒Work ❒Other

How did you hear about LPCC?

Email: ____ ____

EMPLOYER & STATUS

Current Occupation/Employer/School:

____

❒ Self-employed ❒ Unemployed ❒ Retired

EMERGENCY CONTACT INFO

Notify:_____________________________________ Phone: ____________________________

Relationship to client: ____

BILLING INFORMATION

(Please complete if person responsible is not the client)

Name of person responsible:____

Relationship to client: _____________________ Home Phone: _______________________

Address: ____

City/State/Zip: ____

Employer: _________________________________ Employer Phone: ___________________

Employer Address: ____

Employer City/State/Zip____

HEALTH AND MEDICAL

Have you ever been to our office before? ❐Yes ❐No

Do you prefer a male or female therapist? ❐Male ❐Female ❐No preference

Primary Care Physician:____________________________Phone: __________________

Psychiatrist: __________________________________Phone: __________________

Is your Primary Care Physician aware you are seeking counseling services? ❐Yes ❐No

Please list any medical problems: ____

Please list any current medications (include quantities):______________________________

ADDITIONAL INFO

Are you required by a court of law to receive counseling as part of a legal proceeding? ❐Yes ❐No

Are you currently affiliated with any of LPCC's volunteer or adjunctive programs? ❐Yes ❐No

Please complete this form and bring it with you on your first visit. Thank you!