

Judy Nightingale Person, M.A.
Marriage and Family Therapist: License # MFT 021748
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CLIENT INFORMATION FORM

Client Name: _____ **DOB:** _____ **Age** _____
Address: _____ **City** _____ **ZIP** _____
Home Phone:(____) _____ **Work Phone:**(____) _____ **Sex:** M F
Cell (____) _____ **Email (optional)** _____

Please check:
Single ____; Living with partner ____ (# of years ____); married ____ (# of years ____);
divorced ____ (# of years ____); separated ____ (How long? ____); widowed _____.

Partner's name, address and phone numbers (if applicable):
Name: _____ **DOB:** _____ **Age** _____
Address: _____ **City** _____ **ZIP** _____
Home Phone:(____) _____ **Work Phone:**(____) _____ **Sex:** M F
Cell (____) _____ **Email (optional)** _____

If client is under age 18, provide information on parent(s) or guardian(s):
Name(s): _____
Address: _____
_____ **City** _____ **ZIP** _____
Home Phone: (____) _____ **Work Phone:** (____) _____ **Cell** (____) _____

Client's (or Parent's) Employer:

Partner's Employer: _____

Children's Names:

_____	Age: _____	At home: Y N
_____	Age: _____	At home: Y N
_____	Age: _____	At home: Y N
_____	Age: _____	At home: Y N

Religious Affiliation (if any)

In case of emergency, nearest relative: _____
Address and Phone #'s _____

Primary-Care Physician:
Name: _____
Address: _____ **Phone** _____ **FAX** _____

May I please contact your physician so as to coordinate your care? Y N

Do you have any medical illnesses or allergies? Y N

If YES, please list: _____

Referred by: _____

I give permission to Judy Person to contact the person who referred me in order to let him/her know I came for an initial visit. Y N

Have you ever visited a counselor/psychotherapist before? Y N

Please fill out the following ONLY if you would like to use your Visa or Master card for payment. Please note your billing statement will say Argonaut Therapeutic Services, not J. Person, MFT. Your card will be charged the day of your appt.

Check one: Visa _____ M/C _____ CARD # _____

EXPIRATION date _____; Security 3 digit code on back of card: _____

Name on card: _____

Phone AND ZIPCODE associated with the card: _____, _____

Sessions & Fees:

Counseling sessions usually last 50 minutes.

Your fee will be: _____

Cancellations within 48 hours will be billed at the full rate

(Please see accompanying "office policies and general information agreement")

I (we) understand and agree to these conditions.

Signed: _____ **Date:** _____

_____ **Date:** _____

Client(s)/Parent/Guardian