EMILY E. SHOEMAKER, PLLC
EMILY E. SHOEMAKER, MA, LMFT

PLEASE COMPLETE THE FOLLOWING:

CLIENT NAME: ____ DATE OF BIRTH: __________

GENDER: ____ Male ____ Female ____ Transgender

ADDRESS: ________________________________ CITY/STATE/ZIP: _________________________

OCCUPATION: _______________________________ EMPLOYER: _________________________

HOME PHONE #:____________________________ CELL #:______________________________

EMAIL ADDRESS: ____

(For appointment reminders, billing or scheduling purposes only)

Preferred appointment reminder method (check one): ___ Call ___ Text ___ Email

Reminder phone call # (check one): ____ Home ____ Cell

HOW DID YOU HEAR ABOUT ME?____

PRESENTING CONCERN:____

IF CLIENT IS UNDER 18:

PARENT NAME: ____ DOB: ________________

SPOUSE/PARTNER NAME: ____________________________________ DOB:_________________

SIBLINGS OF CLIENT (NAMES AND DOB):____

____

HAVE YOU BEEN IN COUNSELING BEFORE? ____No ____Yes If Yes, Where?________________

Primary Care Physician/Clinic: ____

Date of last physical exam:____

Current Medication List: ____

PRIMARY INSURANCE: (leave blank if you have your card with you)

INSURANCE NAME:____

ID#:____________________________________ GROUP#: _______________________________

Secondary Insurance? ____ No ____ Yes If Yes, name of secondary______________________

____ ____________________________

Signature of Client/Parent/Legal Guardian Date