Kathleen Pearce, LCSW-C, Psychotherapist, Addictions Counselor
Peace of Mind Wellness, LLC

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Confidential Client Information Form

NAME_____ **Today's Date** _____/_____/_____

Birthdate ____/____/_____ Marital Status [ ] S [ ] M [ ] D [ ] W

Address _____ City _____ Zip _____

How were you referred? _____ May I thank them? [ ] Y [ ] N

Your Email _____

May I send statements or other information to your email? [ ] Yes [ ] No

Cell phone _____ Messages [ ] OK Text or voice [ ] No messages

Home phone _____ Messages [ ] OK voicemail [ ] No messages

Work phone _____ Messages [ ] OK voicemail [ ] No messages

SPOUSE/SIGNIFICANT OTHER/PARENT(S):

Name(s) _____

Address _____ City _____ Zip _____

Cell Phone(s) _____ Email(s): _____

If Minor: Please list Cells & Emails for both parents or guardian._

OTHERS LIVING IN THE HOME (INCLUDING CHILDREN):

Name _____ Birthdate ____/_____/_____

Name _____ Birthdate ____/_____/_____

Name _____ Birthdate ____/_____/_____

EMERGENCY CONTACT:

Name _____Cell: _____Email: _____ Relationship _____