COUPLES INSTITUTE
OF
SANTA BARBARA
COUNSELING • WORKSHOPS • TRAININGS

CLIENT INFORMATION FORM

Name (Partner 1):_____ Age:_____ Date of Birth:_____

Address:_____ City:_____ Zip Code: _____

Home Phone: _____ Social Security #: _____

Email: _____ Work Phone: _____

Occupation: _____ Employer: _____

Marital Status: S M D W Name of spouse/partner: _____

Spouse/partner Information: Occupation: _____ Age: _____

Employer: _____ Work Phone:_____

For Couples Counseling:

Name (Partner 2) :_____ Age:_____ Date of Birth:_____

Address:_____ City:_____ Zip Code: _____

Home Phone: _____ Social Security #: _____

Email: _____ Work Phone: _____

Occupation: _____ Employer: _____

Names and Ages of Children (place an "x" next to those children living in your home):

_____

Current Physician and medications prescribed: _____

Emergency Contact (Name/Phone/Relationship):_____

Credit Card Number: _____ Exp. Date:_____

Name on Card: _____ 3 Digit Security Code: _____

I authorize the above method of payment to be applied toward copays or any balance due at the beginning of each month to pre-pay for any sessions scheduled that month.

Signature: _____ Date: _____