



THERAPY AT THE BEACH

CLIENT CONTACT INFORMATION

DATE: _____

NAME: _____

PERSONAL PRONOUNS: _____

AGE: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PRIMARY PHONE: _____

SECONDARY PHONE: _____

OK to leave messages?: _____ OK to text?: _____

EMAIL: _____

May I email you?: _____

**Please note: Email and text correspondence are not considered a confidential medium of communication.*

OCCUPATION: _____

PLACE OF EMPLOYMENT: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

PHONE: _____

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LICENSED MARRIAGE AND FAMILY THERAPIST