**Client Information**

***(Please complete if client is over age 18)***

**Client Name:**  Date:

Age: Date of Birth: Gender (Please Circle): **M** **F**

Address: Home # ( )

City: State: Zip: Cell # ( )

Email Address: (optional):

***Would you like to receive appointment reminders by:*** *Text Email Neither*

**Employer Name:**

Employer Address:

Work Phone: Ext# Occupation:

**Emergency Contact:** Phone # ( )

Marital Status (Please Circle): **Single Married Divorced Widowed Partnered Other**

Name of Spouse/ Partner: Age: DOB:

Address (if different from above):

City: State: Zip: Phone # ( )

Employer:

Were you referred to this office? **Yes No** If so, by whom?

Primary Physician: Psychiatrist:

***Hope & Healing Counseling, LLC***

*1200 Valley West Drive, Suite 304-04*

*West Des Moines, IA 50266*

*(515) 421-4367*