Better Mental Health Services
1684 E. Gude Dr, Suite 102
Rockville, MD 20850

Client Information

Name: ____ DOB: __________________

Address: ____

City: __________________________________ State: ____________ Zip: ______________

Cell Phone: _________________________ Home Phone: ____________________________

Email Address: ____

Pronouns: ___________________ Gender Assigned at Birth: _________________________

Preferred Method of Communication: Cell Phone ☐ Home Phone ☐ Email ☐

Please tell us a bit about why you are seeking therapy:
____
____
____

Emergency Contact Information

Emergency Contact Name: ____

Emergency Contact Phone Number: ____

Relationship to Client: ____

____Date: _____________
Client Signature

____Date: _____________
Parent or Guardian Signature (if applicable