Restoration Counseling Center

Christine Holliday MA, LMHC

Confidential New Client Information Form

GENERAL INFORMATION

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full Name: Mr. / Mrs. / Ms. / Miss / Dr. / Rev. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name You Prefer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_Sex: Male/Female\_\_\_\_\_\_\_\_

Ethnicity: White / Black / Hispanic / Asian /Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Suite/Apartment # \_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we send mail here: \_\_\_ Yes / \_\_\_ No

Mailing Address or Post Office Box: \_\_\_ Same as above

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Suite/Apartment #\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we send mail here: \_\_\_ Yes / \_\_\_ No

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Call you here? \_\_\_ Yes \_\_\_ No Message here? \_\_\_ Yes \_\_\_ No

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Call you here? \_\_\_ Yes \_\_\_ No Message here? \_\_\_ Yes \_\_\_ No

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Call you here? \_\_\_ Yes \_\_\_ No Message here? \_\_\_ Yes \_\_\_ No

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May We Send Email Here? \_\_\_ Yes \_\_\_ No

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average Hours Worked Per Week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average Annual Salary: \_\_\_ $0 –27,000 \_\_\_ 27,001 –55,000 \_\_\_ 55,001 –80,000 \_\_\_ More Than 80,000

Last Year of School Completed: \_\_\_ 9 \_\_\_ 10 \_\_\_ 11 \_\_\_ 12 \_\_\_ GED College: \_\_\_1 \_\_\_ 2 \_\_\_3 \_\_\_4 Other: \_\_\_\_\_\_

Are You Currently In School? \_\_\_ Yes \_\_\_ No

If Yes, What Level: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degree Pursuing: \_\_\_\_\_\_\_\_\_\_\_\_\_

Do You Regularly Attend A Place Of Worship? \_\_\_ Yes \_\_\_ No

If Yes, Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONAL INFORMATION

Current Marital Status: \_\_\_ Single \_\_\_ Dating \_\_\_ Engaged \_\_\_ Married \_\_\_Separated \_\_\_ Divorced \_\_\_ Widowed

Are You Content with Your Current Status: \_\_\_ Yes \_\_\_ No

If No, Briefly Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Dating, Engaged, Married, Separated, Divorced or Widowed, How Long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Previous Marriages for You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Your Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner’s Name: Mr. / Mrs. / Ms. / Miss / Dr. / Rev. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Long Have You Known Your Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Partner’s Ethnicity: White / Black / Hispanic / Asian /

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male / Female

Partner’s Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Average Hours Worked Per Week: \_\_\_\_\_\_\_\_\_\_\_\_\_

Education Partner Completed: \_\_\_ 9 \_\_\_ 10 \_\_\_ 11 \_\_\_ 12 \_\_\_GED College: \_\_\_1 \_\_\_ 2 \_\_\_3 \_\_\_4 other: \_\_\_\_\_\_\_\_

What Words Would You Use to Describe Your Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is Your Partner Supportive of You Seeking Counseling: \_\_\_ Yes \_\_\_ No \_\_\_ Unsure \_\_\_ Partner Does Not Know

With whom do you Currently Live (check all that apply) \_\_\_ Alone

\_\_\_ Spouse \_\_\_ Children \_\_\_ Parent(s) \_\_\_ Sibling(s) \_\_\_Boyfriend \_\_\_ Girlfriend \_\_\_ Roommate \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILDREN

List Your Children (including step, adopted, foster) below:

(Use back if necessary)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name/ Sex | Age or year of death | Relationship to you (e.g., Natural, Adopted, Step) | Living with whom? | Describe him/her in a few words |
|  |  |  |  |  |
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|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Have You Ever Placed a Child for Adoption? \_\_\_ Yes \_\_\_ No

If Yes, When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have You Ever Had a Miscarriage or Medical Abortion? \_\_\_ Yes \_\_\_ No

If Yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family who have had significant involvement. (Use Back if Necessary)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Age or year of death | Occupation | Relationship to you (e.g., mother, father, sibling, step-relation) | Give 2-3 words to describe him/her |
|  |  |  |  |  |
|  |  |  |  |  |
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MEDICAL INFORMATION

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Any Medical Conditions, Illnesses, Treatments, or Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improves \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevents \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Controls \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improves \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevents \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Controls \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improves \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prevents \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Controls \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You Taking these Medication(s) According to Your Doctor’s Recommendations: \_\_\_ Yes \_\_\_ No

Your Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Has Your Weight changed in the Last 2 -3 Months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are You Presently Experiencing Any Suicidal Thoughts? \_\_\_ Yes \_\_\_ No

Have you ever experienced them in the Past? \_\_\_ Yes \_\_\_ No

Have you ever Attempted Suicide? \_\_\_ Yes \_\_\_ No

If Yes, When and How: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have Any of Your Friends or Family Ever Committed or Attempted Suicide? \_\_\_ Yes \_\_\_ No

If Yes, When and Who:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRESENT ISSUES

Please check any of the Following symptoms or problems that you are presently experiencing or have experienced in the past.

|  |  |  |
| --- | --- | --- |
| Stress: | Present | Past |
| Anxiety or Worry: | Present | Past |
| Panic: | Present | Past |
| Depression: | Present | Past |
| Crying all the time: | Present | Past |
| Lack of Motivation: | Present | Past |
| Fatigue/Lack of energy: | Present | Past |
| Poor appetite: | Present | Past |
| Overeating: | Present | Past |
| Trouble Sleeping: | Present | Past |
| Feeling worthless or inferior: | Present | Past |
| Guilt: | Present | Past |
| Death of friend or loved one: | Present | Past |
| Grief: | Present | Past |
| Chronic pain: | Present | Past |
| Physical disability: | Present | Past |
| Terminal illness: | Present | Past |
| Health concerns: | Present | Past |
| Loneliness: | Present | Past |
| Fears: | Present | Past |
| Shyness: | Present | Past |
| Low self-esteem: | Present | Past |
| Marital Problems: | Present | Past |
| Other relational problems: | Present | Past |
| Parenting problems: | Present | Past |
| Physical abuse: | Present | Past |
| Emotional abuse: | Present | Past |
| Verbal abuse: | Present | Past |
| Sexual abuse: | Present | Past |
| Sexual problems: | Present | Past |
| Gender identity: | Present | Past |
| Anger: | Present | Past |
| Apathy: | Present | Past |
| Hopelessness: | Present | Past |
| Aggressive behavior: | Present | Past |
| Bad dreams: | Present | Past |
| Unwanted memories: | Present | Past |
| Loss of control: | Present | Past |
| Impulsive behavior: | Present | Past |
| Controlling: | Present | Past |
| Controlled by others: | Present | Past |
| Obsessive thoughts: | Present | Past |
| Compulsive behaviors: | Present | Past |
| Seeing things others don’t see: | Present | Past |
| Hearing voices: | Present | Past |
| Racing thoughts: | Present | Past |
| Eating problems: | Present | Past |
| Drug use: | Present | Past |
| Alcohol use: | Present | Past |
| Pregnancy: | Present | Past |
| Abortion: | Present | Past |
| Legal matters: | Present | Past |
| Indecisiveness: | Present | Past |
| Lack of discipline: | Present | Past |
| Financial problems: | Present | Past |
| Spiritual apathy: | Present | Past |
| Other: | Present | Past |

PHYSIOLOGICAL SYMPTOMS

|  |  |  |
| --- | --- | --- |
| Headaches: | Present | Past |
| Dizziness: | Present | Past |
| Stomach trouble: | Present | Past |
| Visual trouble: | Present | Past |
| Sleep trouble: | Present | Past |
| Weakness: | Present | Past |
| Muscle tension: | Present | Past |
| Rapid Heart Rate: | Present | Paste |
| Difficulty Breathing: | Present | Past |
| Intestinal trouble: | Present | Past |
| Hearing Noises: | Present | Past |
| Change in Appetite: | Present | Past |
| Fatigue: | Present | Past |
| Pain: | Present | Past |
| Other: | Present | Past |

Please Use an “X” on the Scale Below to Indicate How Distressing Your Problem(s) are to you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1 2 3 4 5 6 7 8 9 10

(Minimally Distressing) (Extremely Distressing)

Please Describe Why You are Coming to Counseling (i.e., What are you issues, problems?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why Have You Decided to Come for Counseling Now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do You Hope to Gain or Change by Coming to Counseling? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How Long Do You Think Counseling Should Last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREVIOUS COUNSELING

List any Previous Counseling, Psychiatric Treatment, or Residential / in-Patient Care You Have Received (Use back if Necessary):

Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TERMS OF SERVICE

I understand that it is customary to pay for services when rendered. I accept full responsibility for payment of any balance incurred for services. I further understand that without 24 –hour notice of intention to cancel, I will be charged the full administrative fee for service.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_