Rooted Mind
COUNSELING CENTER

1247 Milwaukee Ave. Suite# 208 Glenview, IL. 60025~224.257.4190

Client Information Form

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY**

Client Information:

Date_____ Social Security #_____

First Name_____Last Name_____MI_____

Address_____City_____State_____Zip _____

Telephone (Cell)_____(Home)_____(Work) _____

Birthdate_____Age_____ Gender___F___M

Contact Methods for confirming or cancelling appointments:

Email_____Okay to communciate via e-mail? YES NO _____ initial here

Okay to leave a voicemail to cancel or confirm appointments? YES NO _____ initial here

Emergency Information: In case of emergency, please contact:

Name (1)_____Relationship_____ Phone _____

Name (2) _____Relationship_____ Phone_____

Physician_____Phone_____

Address_____City_____State_____Zip_____

Psychiatrist_____Phone _____

Address_____City_____State_____Zip_____

Are you currently taking any medications: ____yes ____no (include vitamins or herbal supplements)

Medication_____Dosage_____

Medication_____Dosage_____

Medication_____Dosage_____

Allergies_____

Referral Source

How did you hear about Rooted Mind Counseling Center?_____