Therapeutic Freedom
9701 Apollo Drive
Largo, MD 20774

# New Client Information Form

Client FULL Name: _____ DOB: _____

Age: _____ (person being seen today) Gender: ___M ___ F

Marital Status: ___Single ___ Married ___ Separated ____Divorced

Address: _____

City: _____ State:_____ Zip:_____

Home Ph: _____ Cell Ph: _____

Email: _____

Occupation: _____

Parent/Guardian (if a minor): _____

Ph:_____ Relationship to Client_____

Languages Spoken: _____

Emergency Contact Name: _____

Phone_____

Services Requested (please check all that apply): __Individual Therapy ___ Family Therapy

Referred By: _____

How did you hear about us? _____

**By my signature, I acknowledge that the information above is true and correct.**
**Client Signature Date (or Parent/Guardian, if under 18):**

_____

**Date:** _____