Believe in Hope Counseling, LLC
Deborah Stramella, MSW, LCSW, LCSW-C

Client Information

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ (Check one) ☐ Cell ☐ Home ☐ Work ☐ Office

Email: _____

Employer/School: _____

Occupation: _____

List all medical conditions and medications _____

List all allergies _____

(Emergency Contact will only be spoken to in the case of a medical or mental health emergency.)

Emergency Contact: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Contact in the event client is a minor:

Name: _____

Relationship: _____

Phone: _____

Client's Signature: _____ Date: _____