

Dr. Thomas A. Parker & Associates



New Client Information

Client Name _____
Last First Middle/Maiden

Today's Date _____ Date of First Appointment _____

Current Address _____

May we contact you by phone? Yes No. If so, (H) _____ (W) _____ (C) _____

May we contact you by email? If so, email address _____

Have you sought counseling before? No Yes. If yes, counselor's name _____

Do we have permission to contact that counselor, if necessary? No Yes. If so, Telephone Number _____

***Date your presenting problem first began: ____/____/____

Who referred you to our services? _____

Is there a personal crisis for which you feel you need help immediately? Yes No

EMERGENCY CONTACT INFORMATION

Contact person in case of emergency _____ Tele. No. _____

Services you are seeking: Individual Couples Group Workshop Consultation

PERSONAL INFORMATION

Age ____ Date of Birth _____ Sex: Male Female

Relationship status

Race/Ethnicity

Dating Regularly

African American/Black

Divorced

Asian American

Married/Partnered

Caucasian

Single

Hispanic

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THANK YOU

Website Addresses: www.drthomasaparker.com or www.stressrejectersnation.com

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