Carol A Lawrence
Associates, LLC
Trauma & Adoption
Counseling

Client Registration Form

Today's Date_____

Client's Full Name_____

Home Address:_____

City:_____State:_____ Zip:_____

Home phone:_____ Can a message be left at this number? YES/NO

Work phone: _____ Can a message be left at this number? YES/NO

Mobile phone: _____ Can a message be left at this number? YES/NO

Would you like to receive text reminders of your session? YES/NO

Initial_____

Email_____

Date of Birth: _____ Gender:_____

Primary Care Physician:_____

Person to Contact in Case of Emergency_____

Emergency Contact Phone Number_____

Reason for attending counseling:

_____

Patient Name

_____

Patient/Guardian Signature Date