

CLIENT DEMOGRAPHIC FORM

CLIENT'S Full Name: _____ **Marital Status:** _____
First Middle Last

Is this your legal name? YES NO If **NO**, what is your legal name? _____

Date of Birth: _____ Age: _____ Gender: MALE FEMALE

Street Address: _____ Home Phone No: _____

City/State/Zip: _____ Cell Phone No: _____

Occupation: _____ Employer: _____ Work Phone No: _____

Student: YES NO School: _____ No. of Yrs. Attended: _____ Graduate: YES NO

Email: _____ Alternate Email: _____

Therapist: _____ Social Security Number: _____

Referred to Provider by *(Please check box)*:

- DR. _____ FRIEND FAMILY COLLEAGUE COURT ORDER
 WEBSITE: _____ Close to: HOME WORK OTHER: _____

Contact Authorization

What number may Texas PCS leave a message on: HOME CELL WORK OTHER: _____

May Texas PCS leave messages with a spouse or other? YES NO

If **YES**, Spouses or Other's Name: _____

Service(s) for Which You Are Seeking

- INDIVIDUAL COUPLES FAMILY GROUP
 PARENTING ISSUES CO-PARENT COUNSELING REUNIFICATION THERAPY SEXUAL BEHAVIOR
 ASSESSMENT: _____ OTHER: _____

In Case of Emergency

Name <small>(Whom to contact?)</small>	Relationship <small>(Natural, step, half, etc.)</small>	Home Phone	Mobile Phone	Work Phone

Signature: _____ Date: _____