LIFEPULSE CENTER™
for Development & Growth
Faith Nouri, PhD, LPC

NEW CLIENT INFORMATION SHEET

Today's Date: _____

Name (print): _____ **Gender:** _____ _____
(Last) (First) (Middle) (male) (female)

Soc. Sec. No.:___ ___ ___ - ___ ___ -___ ___ ___ ___

Date of Birth: ___-___-___ **Age:** ____

E-mail Address: _____

Referral Source: _____

Home Address: _____ **Home Phone:** _____

_____ **Cell Phone:** _____

_____

Business Name & Address:

_____ **Work Phone:** _____

_____

_____

Occupation: _____

Highest Academic Degree: _____ **Major:** _____

Emergency Contact: _____

Phone Number: _____

Would you like to receive our Newsletter through:

_____ **Regular Mail**
_____ **E-mail**

Please help me learn more about you by responding to the following questions:

Family members living with you:

Name	Relationship	Age	Sex

Children (if not in the above list):

Name	Age	Sex	Name of child's other parent

Other currently significant individuals in your life:

Name	Relationship	Age	Sex

Marriages or significant relationships:

Name	Dates

_____ _____

List the members of your family of origin. List your siblings in their correct birth order including yourself.

Name	Age	Sex	If deceased, give age date/ cause of death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Did your parents divorce? _____ If yes, when? _____ How old were you then? _____
Who did you reside with? _____

Do you exercise? _____ If yes, what type? _____How often? _____

Do you smoke cigarettes? _____ if yes, how many per day? _____

Do you drink alcohol? _____ if yes, how much per week? _____

Do you use other drugs, prescription or otherwise? _____

If yes, please name: _____ How often? _____
_____ How often? _____
_____ How often? _____

Are you aware of a history of medical/metal health issues in your family? If yes, please describe.

_____

_____

_____

Have you previously used any type of mental health services? _____

If yes, approximate date: _____ Therapist: _____

Reason for seeking help: _____

Please describe the reason/s for seeking counseling now.

_____

_____

_____

_____

_____

_____

Is there anything else you want me to know about you?

_____

_____

_____

_____

Please Note:

Services at LifePulse Center include, but are not limited to, individual therapy, group therapy, parenting consultations, and corporate consultations, as well as play and activity therapy for children and adolescents. Individual sessions are 45-50 minutes. I am responsible for payments at the time of services.

Signature: _____

Date: _____

CONSENT FOR RELEASE OF RECORDS
(Optional)

(PLEASE CHECK ALL THAT APPLY)

__ I hereby authorize Dr. Nouri to release ____ assessment and/or ____ counseling records for client named below to agent or individual named below.

__ I hereby authorize Dr.Nouri to request ___educational, ___psychological and/or _____medical records for client named below from agent named below. Date of services_____

__ I hereby authorize Dr. Nouri to consult with appropriate school personnel, medical professional and/or mental health professional named below for client named below.

_____
Client (Print name)

_____
Agency/School

_____
Name of Service Provider & Title

_____
Address

_____
City, State & Zip

_____ _____
Client or Managing Conservator's Signature Therapist

_____ _____
Date Date