

**Client
Information**

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TODAY'S DATE: _____

CLIENT:

NAME: _____ **SEX:** ___ **BIRTH DATE:** _____ **AGE:** _____

If Minor, PARENT(s)/GUARDIAN(s): _____

ADDRESS:

STREET: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMAIL:

_____ (OK to email?) YES / NO

PHONES :

(Home) _____ (OK to call?) YES / NO (OK to leave msg?) YES / NO

(Cell) _____ (OK to call?) YES / NO (OK to leave msg?) YES / NO
(OK to text?) YES / NO

(Work) _____ (OK to call?) YES / NO (OK to leave msg?) YES / NO

CLIENT'S EMPLOYER / SCHOOL:

_____ **OCCUPATION:** _____ **HIGHEST LEVEL**
EDUCATION _____

SPOUSE/PARTNER:

NAME: _____ **PHONE:** _____

RELATIONSHIP

STATUS: () Single () Married (years) _____ () Separated () Divorced () Widow/er () Other

EMERGENCY CONTACT:

_____ **PHONE:** _____

RELATIONSHIP: _____ **REFERRED BY:** _____

FAMILY INFORMATION: (Spouse, Children, Parents, Relatives, Others)

NAME **AGE** **RELATIONSHIP** **NAME** **AGE** **RELATIONSHIP**

MEDICAL INFORMATION:

Primary Care Physician: _____ **PHONE:** _____

Other Physicians Treating You: _____ **PHONE:** _____

Current Medications: _____
