

## Client Information

Date \_\_\_\_\_ Clients SS # \_\_\_\_\_  
Client's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Email Address \_\_\_\_\_  
Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Gender: M \_\_\_\_\_ F \_\_\_\_\_ Race \_\_\_\_\_  
Name of Spouse/Parent/Guardian \_\_\_\_\_ Telephone \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Name of Parent/Guardian \_\_\_\_\_ Telephone \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Person Responsible for Payment \_\_\_\_\_ SS# \_\_\_\_\_  
Signature of Person Responsible for Payment X \_\_\_\_\_ (must be signed for service to begin)

### Emergency Information

In case of emergency, contact:

Name (1) \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

Name (2) \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

Physician \_\_\_\_\_ Telephone \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Telephone \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

Other Physicians \_\_\_\_\_ Telephone \_\_\_\_\_

Other Contacts \_\_\_\_\_ Telephone \_\_\_\_\_

Current Medication \_\_\_\_\_  
Allergies \_\_\_\_\_

### Employment Information (If client is a minor, use parent's employment)

Client/Guardian: \_\_\_\_\_ Telephone \_\_\_\_\_  
Spouse: \_\_\_\_\_ Telephone \_\_\_\_\_

### Referral Information:

How did you hear about my services? \_\_\_\_\_  
May I thank them? Y \_\_\_\_\_ N \_\_\_\_\_

### Palo Alto Parenting Solutions

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