Stephen L. McCown, LPC
800 Hwy 290 West, Bldg. D #500
Dripping Springs, TX 78620
512-786-4844

CLIENT INFORMATION

Your name: ____ Date: ____________

Name you would like to be addressed by: ____________________

Address: ____

____

Home Phone: _____________ Cell: ________________ Work: ________________

May I leave a message at (check if Yes): _______ Home ______ Cell ________ Work

Date of birth: _________________ Gender: __________

Marital status (circle): Single Domestic Partner Married Separated Divorced Widowed

Name of spouse or partner: ________________________

Other household members:

Name	Relationship	Age

Primary care physician: ___________________________ Phone: ________________

Date of last physical: ___________________________

Psychiatrist: ___________________________ Phone: ________________

EMERGENCY CONTACT INFORMATION

Name: ____ Phone: ____________________

Address: ____

____

Relationship to you: ____

CONSENT TO CONTACT FOR SCHEDLING/RE-SCHEDULING APPOINTMENTS

You give specific consent to me to contact you or the following person(s) by telephone, including leaving a message via answering machine or voice mail, for the purpose of scheduling or re-scheduling appointments:

Name: ____ Phone: ____________________

Name: ____ Phone: ____________________

Thank you for taking the time to complete this client information form. I look forward to talking with you in your counseling sessions.

________________________________ ________________________________

Signature of client Parent or legal guardian signature

________________________________ ________________________________

Printed name Printed name

________________________________ ________________________________

Date Date