

**Kathleen Dunbar, MA, CHT, Licensed Marriage and Family Therapist #MFC 39880**

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**CLIENT INFORMATION FORM**

**Please provide the information requested below. All information will be kept  
confidential.**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number (if using insurance): \_\_\_\_\_

Phone: (Home): \_\_\_\_\_ (Work): \_\_\_\_\_

(Cell): \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Current Employment: \_\_\_\_\_

Relationship Status: Single: \_\_\_ Partnered: \_\_\_ Married: \_\_\_ Children: \_\_\_

How did you hear about Kathleen? \_\_\_\_\_

Specify any medical or psychological treatment you are currently receiving:

\_\_\_\_\_ Medicine you are taking: \_\_\_\_\_

Have you ever been hospitalized for a psychological issue? \_\_\_\_\_

What is your health insurance coverage? \_\_\_\_\_

Who will pay for your treatment? \_\_\_\_\_

In case of emergency, contact \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Relationship to emergency contact: \_\_\_\_\_