Janet A. Sullivan, MS, LPC
5900 Memorial Drive, Suite 216 C
Houston, TX 77007

CLIENT INFORMATION

Client Name:_____

Street Address:_____

City, State, Zip:_____

Age: _____ Date of Birth:_____

Gender: □Male □Female Marital Status: □Married □Single □Other
Work Status: □Employed □Unemployed □Full-time Student □Part-time Student
Education level: _____

Employer/School & Address:_____
_____

Others living at home: _____

Home Phone:_____May I leave a voice message? Y N
Work Phone: _____May I leave a voice message? Y N
Cell Phone: _____May I leave a voice message or text? Y N
Email:_____May I send an email? Y N
(Please be aware that email and text messages are not secure and therefore I cannot protect your privacy should you choose contact with me through these modes of communication.)

Have you seen a therapist or counselor before? □ yes □ no
If yes, when and with whom? _____
_____
What did you seek counseling for? _____
_____
List any significant health problems:_____
List any medications you are taking and dosage: _____

Primary Care Physician Information
PCP Name:_____
PCP Address:_____
Phone Number:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Referral Information
How did you hear about me? _____
Referred by: _____
Address: _____
Phone Number:_____ May I thank him/her for referring you? □ yes □ no

_____ _____
Client Signature Date

ADOLESCENT CONSENT TO TREATMENT

Name (please print): _____ Birth date: _____
(last name) (first) (middle)

I certify that I am the ☐ father, ☐ mother, ☐ legal guardian of the above named adolescent and that I have legal custody of the above named adolescent. I, hereby, give my authorization and consent for the above named adolescent to receive counseling services from Janet A. Sullivan, MS, LPC.

Parent/Guardian Name (please print):_____

Parent/Guardian Signature: _____ Date: _____