DEBBIE BAUER, M.A., CA #43512
LICENSED MARRIAGE AND FAMILY THERAPIST
Phone: (925) 437-2203

REGISTRATION RECORD – MINOR CLIENT

DATE_____

CLIENT'S NAME_____BIRTHDATE_____

SCHOOL_____GRADE_____

CAREGIVER #1 _____PHONE_____

ADDRESS_____ ALT PHONE_____

OCCUPATION_____EMPLOYER_____

CAREGIVER #2 _____ PHONE_____

ADDRESS_____ ALT PHONE_____

OCCUPATION_____EMPLOYER_____

EMAIL ADDRESS: _____

PERSONS IN HOUSEHOLD	**AGE**	**RELATIONSHIP**

1._____

2._____

3._____

4._____

CLIENT'S PERSONAL PHYSICIAN_____

CURRENT MEDICATIONS_____

REFERRED BY_____

PRIMARY REASON FOR SEEKING THERAPY_____

We have received a copy of the terms and conditions of the office of Debbie Bauer, LMFT, and agree to abide by them. We give voluntary consent to participate in psychotherapy with Debbie Bauer, LMFT.

_____ _____
Responsible Party - Signature Date

_____ _____
Client – Signature Date