Allie Bulliman Counseling
34004 9th Avenue South, Suite A-11, Federal Way, WA 98003

CLIENT REGISTRATION FORM

____
Name Date of Birth Age Soc. Security #

____
Home Address City State Zip

____
Home Phone Mobile phone Work phone Email

____
Place of Employment

____
Marital Status For How Long? Ages of children

Have you had previous therapy or counseling? (circle one) Yes No

If yes, please briefly explain____

How did you hear about Allie Bulliman Counseling?______________________________________

Are you currently under a physician's care (circle one) Yes No

I*f yes*, please specify and list any medications taken __________________________________

____

____
Doctor's Name Doctor's phone

May we identify ourselves if we call your home? (circle one) Yes No Your work? Yes No

____
Name of Person to Notify in Emergency Relationship to Client

____
Address City State Zip Phone

I hereby release the above information to be shared with Allie Bulliman Counseling.

___________________________________ ______________________
Client Signature Date

___________________________________ ______________________
Counselor Signature Date