Academy of Creative Living
SHARON M. BARNES, MSSW, LCSW
THERAPIST FOR SENSITIVE AND GIFTED

CLIENT INFORMATION

Name:_____Date:_____

Street: _____ City, Zip _____

Best Phone Number: _____ OK to leave a message? Y N Birth Date:_____

Other Phone Number: _____OK to call? _____Employer: _____

Email Address: _____ OK to send you our email newsletter? Yes No

Please indicate how best to contact you: _____

Primary Care Physician: _____ Phone: _____

By whom were you referred?: _____ Phone:_____

Address: _____

Reason for Referral :_____ May I send them a Thank-you note? Yes?

If you searched online, how did you find us? (Circle All) Google Yahoo Facebook Twitter Psychology Today Denver Therapists Network MeetUp YouTube Other _____

In Case of Emergency Contact:

Name:_____Relationship: _____

Street, City, Zip: _____ Phone :_____

Person Responsible for the Bill:

Name:_____Relationship: _____

Street, City, Zip: _____ Social Security #:_____

Week Day Phone: _____ Week End/Night Phone: _____

You may release information necessary for billing to this person: _____

Please list all people living in your household:

Name	age	Relationship to you	Occupation/School grade