Jan Phillips, M.A., LPC, LMFT Associate
Jan Phillips Therapy
Client Information

Name ____ Date ___________________

Address ____ Zip ____________________

Telephone: Home ________________ Work ____________________ Mobile ____________________

OK to Leave Messages at all? (if not, please identify which) _____________________________________

Email address ___________________________________ OK to send you information by email? ______

Birth date ____________________________________ Employer _______________________________

Who referred you to Jan Phillips Therapy? ____

Is it ok for me to acknowledge the referrer? ____

Reason for Therapy now ____

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Emergency Contact

Please list contact information for a local person I can contact in case of emergency. This contact will only be used if I believe you or someone else is in immediate danger or if you become ill and unable to continue or depart therapy without assistance.

Emergency Contact Person (Local) ____

Relationship ____

Address ____

Phone Number ____

I agree for my therapist to contact the above named person under the above named conditions.

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Client's Signature Date