Client Name:_______________________________
Client Date of Birth: ________________________

Adult Client Information

Clouse Counseling, LLC/Wildflowers Counseling
Noelle W. Clouse, LMHC
. Email noellewclouse@wildflowerscounseling.net

Date: __________________________

Client Name: _________________________________ DOB: ______________
Gender: _______________________ Age: _____
Address: ____
____
Cell Phone with Area Code: ____________________
Other Phone with Area Code: ____________________ Type of Phone: _________
Email: ____ Type: ________

Reason for seeking counseling:

____
____
____
____

Previous Treatment (Provider Name, location and dates)

____
____
____
____

Previous Diagnosis____

Medication (name, dosage and prescriber)

____
____
____

Primary Care Physician: ____
Address: ____
Phone: ______________________________ Fax: ______________________________