

NEW CLIENT DATA FORM
For PAMELA MILAM, M.A.,
Licensed Professional Counselor

All information you share will be kept confidential with the following exceptions: a) you direct me to tell someone else; b) I determine that you are a danger to yourself or others; c) I am ordered by a court to disclose information. In regards to abuse of a child or elderly person, it is required by law to report all such cases.

Full Name: _____ Sex: _____

Address (with city and zip):

E-mail address: _____ Date of Birth: _____

Phone (Home): _____ (Work) _____

(cell) _____ May we call you at Home? Yes or No

May we call you at Work? Yes or No On Your Cell? Yes or No

Marital Status: _____ Name of significant other: _____

Employer: _____ Position: _____

Employer's Address:

Physical Impairments: _____ Medications: _____

Physician (if any): _____ Phone: _____

Hospitalizations for emotional concerns/substance abuse? _____

How did you hear about this counseling practice? _____

Payment by PayPal, cash, or check? _____

DL# (Not Required) _____ SS# (Not Required) _____

Briefly describe why you have chosen therapy at this time: _____

Your fee is due at the end of each session. Unless you give a 24-hour cancellation notice, you will be charged for your session. If you are filing insurance, request an insurance receipt. Insurance reimbursements should be made directly to you.

Signature: _____ Date: _____