



Heidi Somers, M.A., L.M.F.T.

You were created to thrive.

307.413.4334/PO Box 14865/Jackson, WY 83002

CLIENT INFORMATION

Initial Contact Date: ____/____/____ Time: ____

Client Name: _____ First Name: _____ Middle Initial ____

DOB: ____/____/____ Age: ____ Gender: _____

Client employer: _____

Email address: _____

Mailing Address: _____

Street Address (if different) _____

Home Phone: (____) _____ Cell: (____) _____

How were you referred to me? _____

Household Member's Name	Relationship to client	DOB	AGE	Grade	Occupation

Reason for seeking Counseling: _____

Current & Past Medications related to issue: _____

Previous Counseling/provider and dates: _____

Last Physical Exam date & Provider: _____
Birth Place: _____

Other info you would like me to have: _____

