VINDER LALLIAN, MA, LMFT
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Roseville, CA. 95661

NEW CLIENT INFORMATION

Name: ____Date:___________________________________

Home Phone: ______________________ Work Phone: ___________________ Cell: __________________

Mailing Address: __________________________________ City: ________________________Zip: _______

Date of Birth: __________ Social Security #: _______________ Driver's License#:______________

Employer: ______________________________ Occupation: ______________________________________

Spouse/Partner's Name: _____________________________ Marital Status: S___ M ___D ___W___

Home Phone: ______________________ Work Phone: ___________________ Cell: __________________

Date of Birth: __________ Social Security #: _______________ Driver's License#:______________

Employer: ______________________________ Occupation: ______________________________________

Email:____ Who referred you? __________________________

Medications ___________________ Prescribing Physician ________________ Phone: _____________
___________________ Prescribing Physician ________________Phone: _____________

Emergency Contact: ________________________________ Phone:_______________________________
(If it becomes necessary to contact this individual, only that information required to keep you safe will be disclosed.)

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Briefly explain your hope in coming to therapy:

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____________________________________ ____________________________________
Client or Authorized Person's/Guardian's Signature **Acknowledgement of receipt of Privacy Policy**

____________________________________ ____________________________________
Client or Authorized Person's/Guardian's Signature **Acknowledgement of receipt of Privacy Policy**