

CLIENT INFORMATION**Ben L. Ashcraft, MS,LMFT**

| | | |
|------------|-----------|------|
| First Name | Last Name | Date |
|------------|-----------|------|

| | | | |
|---------|------|-------|----------|
| Address | City | State | Zip Code |
|---------|------|-------|----------|

| | | |
|------------|--------------|--------------|
| Home Phone | Office Phone | Mobile Phone |
|------------|--------------|--------------|

Email Address _____

Date of birth ____ / ____ / ____ Male ____ Female ____

Single ____ Married ____ Other ____ SS# _____

Employed ____ Full-time Student ____ Part-time Student ____ Other ____

Family Doctor Name/Phone _____

Who referred you? _____

Is there any current or past involvement with The Division of Child and Family Services in the past 12 months? Yes ____ No ____.

EMERGENCY CONTACT INFORMATION

Name _____ Phone _____

PERSON RESPONSIBLE FOR PAYMENT

If client is responsible for bills there is no need to re-enter information here, otherwise complete this section.

| | | |
|-------|------------|-----------|
| Title | First Name | Last Name |
|-------|------------|-----------|

| | | | |
|---------|------|-------|----------|
| Address | City | State | Zip Code |
|---------|------|-------|----------|

| | |
|------------|----------------|
| Home Phone | Business Phone |
|------------|----------------|

Relationship to client _____

FAMILY INFORMATION

Name of Spouse _____ DOB _____

If a minor, name of parent(s) or guardian(s):

Children of an adult, or siblings of a child client, and/or others living at home:(if more than 3 list on back)

| | | | |
|------------|-----------|-----|----------|
| First Name | Last Name | DOB | In Home? |
|------------|-----------|-----|----------|

1. _____

2. _____

3. _____