Carson C. Winn, LCSW

(310) 691-6981

carsoncwinn@gmail.com

Client Information

Client Name _____ Date of Birth_____ Age _____ Gender _____

☐ Minor ☐ Unmarried ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Engaged

Address _____ Cell Phone _____
Number & Street City State Zip Area Code & No.

May I leave a message at the above phone _____yes _____no If not, where may a message be left? _____

E-Mail Address _____ Soc. Sec.# _____ Dr. Lic.# _____

Occupation _____ Work Phone _____
Area Code & No.

Spouse's or Parent's Name _____ Date of Birth _____ Age _____

Soc. Sec. # _____ Dr. Lic. # _____

Address_____
City State Zip

Occupation _____ Work Phone _____
Area Code & No.

In Case of emergency please contact:

Name _____ Phone _____
Relationship Area Code & No.

Address _____
Number & Street City State Zip

Party to Take Financial Responsibility for Counseling (If same as 'client' indicate 'self') – Must sign at bottom

Name _____ Phone _____
Relationship Area Code & No.

Address _____
Number & Street City State Zip

Referred By (if google/internet please specify term searched): _____
Have you received counseling from other professionals in the past? _____Yes _____No
If yes, when and with whom? _____

Medical History

Please list current prescription medications _____
Please list current non-prescription medications _____
List past surgeries or major illnesses and dates _____

Signature(s) _____ Date _____

_____ Date _____

[For Couple. Marital, Pre-Marital, or Family Counseling, both partners/parents must sign]