Susan Brumbaugh, MA, LMHC

Counseling @ St. John's
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CLIENT REGISTRATION FORM

Today's Date:			
CONTACT INFORMATION			
Last name:	First:	Middle Initial:	
Address: [Address/ P.O Box, City, ST ZIP Code]			
Cell phone no.:	Home phone no.:	E-mail address:	
Birth date:	Age:	Sex/Gender:	How did you learn about Counseling @ St. Johns?
REASON FOR COUNSELING			
What brings you to counseling?			
What goals do you have for your time in counseling?			
What do you consider to be some of your strengths?			
What do you consider to be some of your weaknesses?			
IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to client:	Cell phone no.:	Home phone no.:

The above information is true to the best of my knowledge. I understand that I am financially responsible for all charges and that I will receive information I can use to seek reimbursement directly from my insurance provider, if desired.

Client signature _____ Date: _____