Alicia Muñoz, LPC
Individual and Couple Psychotherapy
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New Client Information Form

Client Information

Name _____ Partner's Name _____

Occupation(s) _____

Address _____ City _____ State _____ Zip _____

Phone _____ W / C Emergency Contact _____

Date of Birth/Age _____ Partner's Date of Birth/Age _____

Relationship Status S P M SEP D W Years Together _____

Type of Counseling Sought: Individual / Couple

Psychiatrist _____ Primary Care Doctor _____

Current Medications _____

Referred By _____ Health Insurance _____

Presenting Concern(s) _____

Immediate Family Members

Name	Birthdate	Relationship	Living at Home?
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No
_____	_____	_____	Yes / No

Authorization to Email Communication

I request to have access to Alicia Muñoz, LPC, via electronic communication, including text and email, solely for the purpose of scheduling appointments. I understand that steps have been taken to protect my privacy. However, I know there are risks to my privacy using this method of communication, which I accept.

Client Signature _____ Date _____

Client Signature _____ Date _____

Authorization for Counseling

I/we _____ (printed names) authorize Alicia Muñoz, LPC, to provide counseling services. I/we have received, read and signed the Informed Consent documents.

Client Signature _____ Date _____

Client Signature _____ Date _____