CAROL BUTTERY, M.A. MFT
3468 Mt. Diablo Blvd., Suite B301
Lafayette, CA 94549

Client Information

Date_____

Name_____ Birth date_____

Address_____ Home Phone_____

City_____ Office Phone_____

Occupation_____ Cell Phone_____

What problems or concerns have brought you to therapy?_____

Referred by:_____ Email_____

MEDICAL INFORMATION

Physician's Name_____ Phone_____

Address_____ Date last seen_____

Are you currently under medical care? Yes_____ No _____

Please indicate any chronic conditions_____

Please indicate any medication that you are currently taking_____

Prescribing Physician _____

Previous Counseling Yes _____ No _____ How Long?_____

Therapist_____ Phone _____

Reason for termination of therapy _____

In case of emergency, I grant permission to call:
Name/relationship_____ Phone_____