

Tina Linares LMHC, MFT

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360-420-2093

Today's Date: _____

CLIENT INFORMATION:

Full NAME: _____ BIRTH DATE: _____

Marital Status: (Circle) Single Married Divorced Separated Committed Dating

Employment Status: (Circle) Unemployed Full-Time Part-Time

Student Status: (Circle) Full-Time Part-Time

Current Living Situation: (Circle) With Spouse/Partner With Extended Family

Sole-Residence With Roommates

MAILING ADDRESS: _____

E-Mail Address (Optional): _____

PHONE NUMBERS: _____ (Home) Messages YES/NO
_____ (Cell) Messages YES/NO

Reason for seeking therapy: _____

How did you hear of us? Referral ___ if so, by whom? _____

Is it ok to thank this person for the referral: ___ Yes ___ No

Phone Book ___ Internet _____

Are you taking any medications at this time? ___ Yes ___ No

If so, please list both the medication and the dosage:

