

Jozeffa Greer, LMFT

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CLIENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ ZIP _____

TELEPHONE () _____ () _____ () _____
Home Work Cell

Age _____ Birthdate _____ Email Address _____

CURRENT LIVING SITUATION

Name of Spouse or _____ Age _____
Live-in Partner

Name of Children _____ Age _____

_____ Age _____

_____ Age _____

_____ Age _____

MEDICAL

Current Medical Doctor _____

Present Health: Excellent _____ Good _____ Fair _____ Poor _____

Recurring Health Problem(s): Explain briefly _____

Medication taken for psychological or medical reasons:

Current Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____