

The Center For Tranquility and Restoration

Aileen Nealie, LMFT, DCEP Lic#MFC 40154

Client Information

Name: _____ Date of birth: _____

Gender: Male Female Social Security # _____

Status: Single Married Divorced Separated Widowed Other

Age: _____ Primary Language: _____ Auth # _____

Insurance carrier: _____ Member#: _____

Home Address: _____ City: _____ Zip code: _____

Telephone (s): _____ (Specify home, office or cell)

Do you authorize text messages? Yes No

Best time to reach you: _____ Do you authorize us to leave
a message with our name; with details; or no message at all (Please circle one)

E-mail: _____

Employer name and address: _____

Address: _____ City: _____ Zip code: _____

Reason for visit:

Do you suffer from any medical condition or do you take any medication that should
require special attention? If yes, please specify:

Name of caring physician: _____ Telephone: _____

In case of an emergency I authorize the following person to be contacted: Initial: _____

Name: _____ Telephone: _____

