

CHAT N RELAX COUNSELING & CONSULTATION, LLC ® DaRon Stephens, LMHC, MCAP FLORIDA (P) 201-675-1083

CLIENT INFORMATION

(Please print clearly)

Today's Date:	Date of B	irth:/	Age: Gender:		
Referred by: Self or					
Client Name:					
Address:					
Street		City	State Zip Code	County	
Home Phone:		Cell Phone:			
Height:" Weight:		Eye Color: Hair Color:			
Race:		Ethnicity: (optional)			
Occupation or School N	Tame:				
Parents' Names & Pho	ne: (If client is un	der 18 years of age)			
Mother		Father			
May I text you regardin	g appointment co	nfirmations and/or c	cancellations? Yes or N	0	
May I email you regardi	ng appointment o	confirmations and/or	cancellations? Yes or N	O	
Email:		@			
	<u>Emergen</u>	cy Contacts Inform	nation		
Name(s):					
Relationship:		Phone: _			
Address:					
Street	City	;	State Zip Code County	1	
Name(s):					
Relationship:		Phone: _		·	
Address:					