CONSENT FOR SERVICES

TRACI CAMPBELL

LCSW

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AUSTIN, TX 78704

T 512.921.4215

TraciCampbellLCSW.com

Date:

Personal

Name:

Date of Birth Age:

Sex: Female ____ Male ____ Transgender____ Other ____

Home Address:

City: State: Zip Code:

Home Phone:

Cell Phone:

Work Phone:

Email:

Occupation:

Employer:

Work Address:

City: State: Zip Code:

Single Married Domestic Partner Divorced

Long Term Relationship Widowed

Spouse/Significant Other's Name:

Notify in case of emergency:

Name:

Phone:

Relationship to you:

Children/siblings/parents who live In your home:

Name:

Relationship:

Age:

Referred by:

Relationship:

MEDICAL

Do you have any medical problems? Please explain.

If you are currently under the care of a physician for a continuing health problem, please give me your physician's name and phone number:

Do you take regular medications? If so, please list:

Medication: Dosage: Frequency:

Do you smoke? Yes No

If yes, how much?

Do you drink alcoholic beverages? Yes No

If yes, how much?

Previous Mental Health Services

Type of Services:

Provider :

Dates of Services:

Current or expected legal involvement? Yes ☐ No ☐
If yes, please explain.