HOOPER COUNSELING AND CONSULTATION SERVICES, LLC

Promoting Authenticity in Thinking, Doing, and Being

Connie Bussey-Hooper, LMSW, DCSW, Owner and Mental Health Therapist

CLIENT MEDICAL INFORMATION

Full Legal Name:	**Date of Birth:**	**Gender:**
Psychiatrist Name:	**Psychiatrist Address:**	**Psychiatrist Phone Number:**
How often do you see your Psychiatrist:		
Primary Doctor's Name:	**Primary Doctor's Address:**	**Primary Doctor's Phone Number:**
How often do you see your primary doctor:		

List all current medications:

Medication	**Dosage**	**Frequency**	**Additional Information**

List any allergies:
List any health issues:
If the client has been in therapy before please list the name of the therapist(s), date(s) seen and length of treatment (This is for informational purposes only. We can't contact anyone without your written permission):

I understand that therapists are mandated reporters, and in the event of harm, or threat of harm to myself or others they are required by law to report this information. I understand that in the event of suicidal threat and/or intent, my therapist will need to contact my designated contact person and/or local authorities.

Signature of Client/Parent Guardian: _____ **Date:** _____

Psychological and Behavioral Consultants
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