FREEDOM COUNSELING CENTER, INC.
(269) 982-7200 FAX (269) 982-0202

PATIENT RECORD

Patient: ________________________________Date of Birth: ____________ Age: ___

Sex: ______________ Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Address: __________________ City: _____________ State: ____ Zip: _____________

SS# _____________________ Email: ____

(H) Phone _______________ (W) Phone _____________ (C) Phone _______________

Employer/School: ____

Spouses Name: ___________________ Address (if different): _______________________

Emergency Contact: ______________________ Telephone: _______________________

Reason for Seeking Treatment: ☐Personal ☐Workman's Comp ☐ Legal

Relevant medical conditions (history, current condition, changes in condition): __________
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____

Medications (dosage, dates of initial prescriptions, names of prescribing professional):
____

Previous Counseling: ____

If Client is a Minor (under 18) – Parent, Guardian, or Responsible Party: ______________
____

Address: ____ Phone: ____________________

SS#: ____ Date of Birth: ______________

Employer: ____ Phone:_____________________

Emergency Contact: _________________________________ Phone: _____________________