MIRACLE | Counseling

Client Chart

DEMOGRAPHICS

First name: _____ Last name: _____

DOB: _____ Languages: _____

Address:_____

City, State, Zip: _____

Home Number: _____ Cell Phone: _____

Email:_____

EMPLOYMENT ☐Part time ☐Full time ☐ Not applicable

Location: _____ Position: _____

Phone Number: _____ Email: _____

EDUCATION ☐ Part time ☐Full time ☐ Not applicable

Institution: _____ Level of Education: _____

Phone Number: _____ Email: _____

EMERGENCY CONTACT #1

First name: _____ Last name: _____

DOB:_____ Languages:_____ Relation to client: _____

Address:_____

City, State, Zip: _____

Home Number: _____ Cell Phone: _____

EMERGENCY CONTACT #2

First name: _____ Last name: _____

DOB:_____ Languages:_____ Relation to client: _____

Address:_____

City, State, Zip: _____

Home Number: _____ Cell Phone: _____

ACTIVE *MEDICATIONS* *(use additional paper if needed)*: □Continued

Name of Medication	Quantity	Frequency

DISCONTINUED MEDICATIONS *(use additional paper if needed):* □Continued

Name of Medication	Quantity	Frequency

ALLERGIES *(use additional paper if needed)*: □Continued

Allergy	Reaction	Protocol

This form was completed to the best of my knowledge and ability. It will remain my responsibility to update Miracle Counseling and Life Coaching LLC of any future changes.

_____ _____

Print- Client's Full Name Relation to Client

_____ _____

Signature Date

IF APPLICABLE, ATTACH VERIFICATION, COPY OF HMO, & ADDITIONAL NOTES TO CLIENT CHART.

Initial verification completed by: _____ *On:* _____

Office Personnel *Date*