Tidelands Counseling
1411 Marsh Street, Suite 105, San Luis Obispo, CA 93401
805-543-5060

***TREATMENT TEAM**: MATTHEW CHIRMAN, LMFT #39579, LPCC # 551. KIM RICHARDS, LMFT #53788. COLLEEN RYAN, I-MFT #62940. ELISE THOMPSON, I-MFT #83276. KASSANDRA BOORTZ, I-MFT #77794 JON WISE, I-MFT #86848*

Application for Services

Name: _____

Street Address: _____

City: _____ Zip: _____

Mailing Address (if different): _____

City: _____ Zip: _____

Contact Information	May we contact you with this phone/email?	Messages okay?
Home phone: _____	☐yes ☐no	☐yes ☐no
Work phone: _____	☐yes ☐no	☐yes ☐no
Cell Phone: _____	☐yes ☐no	☐yes ☐no
Email: _____	☐yes ☐no	☐yes ☐no

Date of birth: ____/____/____ Social Security: _____-_____-_____

Gender: M/F Marital Status: single/married/life partner/divorced/widow(er)

Person(s) to notify in case of an emergency:

_____

(name) (phone number) (relationship)

Insurance

Insurance Company: _____

Primary Insured: _____

Member ID Number: _____ Group Number: _____

Insurance Company Contact Number (from card): _____

Address (if on card): _____

Please bring your insurance card with you to your first appointment!

Current Medications

(Name of medication)	(Reason)	(Doctors name)
(Name of medication)	(Reason)	(Doctors name)
(Name of medication)	(Reason)	(Doctors name)

*If others, please attach a list of all medications

Physician: _____
Name, Address, Phone Number

Physician: _____
Name, Address, Phone Number

Who lives with you in your home?

Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship
Name	Age	Relationship

Briefly describe the difficulties you are currently experiencing which caused you to seek out therapy:

What have you tried in the past to resolve these concerns?

Was it helpful? Why or why not?

What would you like to get out of therapy? How would your life be different as a result of therapy?

Is there anything else you would like me to know?

Client signature Date

Client signature Date

Parent or Guardian signature Date