Lifestart Counseling, PLLC

37875 W. 12 Mile Rd. Suite 204
Farmington Hills, MI 48331
(248) 798-4402
(248) 910-1591
(248) 703-2578

CLIENT REGISTRATION

Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Sex _____ Marital Status _____ Birthdate _____ Age _____

Phone Nos.: Home _____ Work _____ Cell _____

Preferred phone no. & time to be contacted at: _____

Spouse or Significant Other: _____

Children's Full Names and Birthdates: (use back of form if more room is needed)

_____ _____

_____ _____

Family Doctor: _____ Phone No.: _____
Address: _____

OB/GYN Doctor: _____ Phone No.: _____
Address: _____

Family Pediatrician: _____ Phone No.: _____
Address: _____

Psychiatrist: _____ Phone No.: _____
Address: _____

Reason for considering counseling at this time: _____
_____
_____
_____

How did you find about Lifestart Counseling's services? _____
_____

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Are you currently participating in Beaumont Hospital's Parenting Program? Yes or No
(please circle one)

CONSENT FOR TREATMENT

I, _____, acknowledge that I am voluntarily seeking treatment and that treatment will be rendered by a professional counselor.

I understand that the successful termination of treatment is determined when the counselor and client agree that the goals of treatment are substantially achieved. However, I also understand that I am free to discontinue treatment on my own at any time.

I understand that I may ask questions concerning any part of my treatment.

_____ Date _____
Client Name – Printed

_____ Date _____
Client Signature