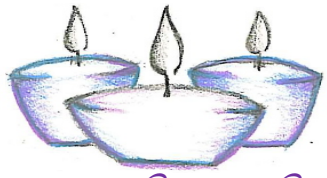
Extrordinary Counseling



*"Your Lights to the future"*

**Client Registration Form**

**Date: _____**

**Client Name: _____**
**Last First Middle**

**Guardian: Name: _____ not applicable**

**Street Address: _____City: _____**

**State: _____ Zip Code: _____**

**Contact No.: Home- (____) _____ Cell-_(_____)_____**

**Gender: ___ Male ____Female Age:_____**

**Employed (circle one): _____YES _____ NO ; Income:_____ week/month/year**

**Do you currently have Health Insurance (circle one): ____YES _____ NO If so,**

**Name of Health Insurance and I.D. number:**

**_____**

**Social Security no.:_____-_____-_____**

**Date of Birth:_____/_____/_____**

**Client's home phone #: (__) _____ Client's Cell phone #: (__) _____**

**Emergency Contact Name: _____Relationship: _____**

**Emergency Contact phone no.:__(_____)_____ ___Home ____Cell**

**Preferred Appointment Day: ____Monday_____Tuesday_____Wednesday_____Thursday**

**Preferred Appointment Time: _____Morning _____Afternoon _____Evening**

**8am-11am 12pm---4pm 5pm—7pm**