Dr. Shari Geller
Supervising Psychologist
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CLIENT CONTACT FORM

(PLEASE MAKE SURE TO FILL OUT THIS FORM ENTIRELY, INDICATING N/A IF NOT APPLICABLE)

Date:_____ Form completed by:_____

Name:_____ Date of Birth:_____ Age:_____

Gender: ☐Male ☐Female ☐Other (Describe):_____

Address_____

City:_____ Province:_____ Postal Code:_____

Home phone:_____ Cell phone: _____

Work phone:_____ Email: _____

Preferred Contact Method: ☐Home ☐Cell ☐Work ☐Email

- ✓ *Please circle at which number(s) it is safe to leave a voicemail.*

PRIMARY PHYSICIAN

Name:_____ Phone #:_____ Date of Last Visit:_____

Address:_____ City:_____ Prov.:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship to Client:_____

Address:_____ City:_____ Prov.:_____

Home #:_____ Cell #:_____ Work #:_____

*IF CHILD OR TEEN

Legal Guardian Name:_____

Relationship to client: ☐Parent ☐Other (check one. If other, specify)_____

Address:_____ City:_____ Prov.:_____

Home #:_____ Cell #:_____ Work #:_____

REFERRAL INFORMATION

Who referred you to this office?_____

If no referral, how did you find out about these services?_____