CLIENT INFORMATION

Eric B. Tedstrom, LCSW, LLC
Family, Group and Individual Counseling

Date:	

Name:		Date of Birth:
Street:		Age:
City, Zip:		List any medication(s) and dosages:
Home Ph:		
Cell Ph:		
Work Ph:		
E-mail:		

Parent info if client is a minor:	Alternate residence (i.e., non-custodial parent):
Mother's name:	
Father's name:	

In case of emergency, contact:		
Name:	Relationship:	Phone:

Please record family members living in client household, and ages:		

Please indicate how you heard about Eric Tedstrom, LCSW, LLC:

❑ Family or Friend ❑ Current or former client ❑ Professional (MD, etc.)

❑ Insurance Company ❑ Other

If possible, please specify: ____

If a professional, please provide contact information: ______________________________

Office use only	❑ Copies to client
DSM IV ________________________	Payment info _____________________