

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

MATTHEW CHIRMAN, LMFT #39579, LPCC # 551. ELISE THOMPSON, LMFT #96198

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: ____ / ____ / ____

Gender: M/F/Trans-male/Trans-female/Gender nonconforming/Other

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: _____

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