



Client Information & Informed Consent

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Courage**

3160 Camino del Rio S #304
San Diego, CA 92108
T 619-819-0283
F 619-819-0284
www.potentiatherapy.com

I am here to see: _____ Date: _____

Client Name: _____

Age: _____ D.O.B: _____ S.S.N.: _____

Occupation: _____

Employer/School: _____

Marital status: Married • Remarried • Single • Single Parent • Widow(er)
Divorced • Separated • Partnered

If applicable, Spouse/Partner's Name: _____

Do you have children? Yes • No

If yes, names & ages _____

Who lives in your home? _____

Home Address: _____

Primary Phone: _____ Secondary Phone: _____

Permanent Address (same as above____)

Have you ever seen a mental health professional (psychiatrist, psychologist,
or counselor)? Yes • No

If yes, when? _____

Please briefly list the reasons: _____



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Are you currently taking any medication? Yes • No

If yes, explain: _____

What brings you to therapy today?

How did you hear about Potentia?

If applicable, may we thank your referral source? Yes • No

Emergency Contact: _____

Phone Number: _____

May your therapist leave a message for you at (Please Circle):

Primary Number: Yes • No

Secondary Number: Yes • No

Can your therapist contact you via email to discuss scheduling and other related issues? Yes • No

Would you like to be included on Potentia's e-list and receive blog and event updates? Yes • No

E-Mail: _____

Signature: _____ Date: _____

Printed Name: _____