Emotional Resource Center
Marlene Kastrinos, Ph.D., L.C.S.W., S.A.P.
Client Information

Name: ____Appointment Date: ____________

Address: ____

____Zip Code: ________________

Phone Number: ___________________________________Work phone: ____________________________

Cell Phone: _____________________________ Date of Birth: ____________________________________

Place of Employment: ____

Occupation: ____________________________________ SS Number: ______________________________

Marital Status: _____________ Spouse's Name: ____

Employer: _____________________________________ SS Number: ______________________________

Date of Birth: ___________________________ Family Doctor: _____________________________________

Medication? ___________ If yes, please state the name and dosage of the medicine and the reason for the medication: ____

Primary Insurance Company: ____

People in Household:

Name: _____________________________________ Age: _______ Relationship: ____________________

Name: _____________________________________ Age: _______ Relationship: ____________________

Name: _____________________________________ Age: _______ Relationship: ____________________

Name: _____________________________________ Age: _______ Relationship: ____________________

Please describe briefly your reason for seeking therapy:

____

Your appointment time is reserved exclusively for you. Please call eight hours in advance to reschedule your appointment, if a change of appointment is needed. **A fee is assessed for a missed appointment or late cancellation. A maximum allowed fee permitted by law will be added to all returned checks. Secur Chex will electronically convert and debit this total amount.**

Signature ____