

Matthews Counseling & Coaching  
145 Little Conestoga Road Chester Springs, PA 19425

Client Information Form

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Ok to send mail? (if necessary for statements, billing, etc):      Y      N

Client Cell Phone: \_\_\_\_\_ Ok to call?      Y      N      Ok to text?      Y      N

Client E-mail: \_\_\_\_\_ Ok to e-mail:      Y      N

Parent/Guardian Cell Phone (if applicable): \_\_\_\_\_

Ok to call?      Y      N      Ok to text?      Y      N

Parent/Guardian E-mail: \_\_\_\_\_ Ok to e-mail: Y      N

How did you find out about the therapist or practice? \_\_\_\_\_

By signing this form, I indicate that the above is correct and staff of Matthews Counseling & Coaching may contact me via the methods above (if indicated) for scheduling, billing, or other purposes in the provision of services. Staff will not communicate with anyone else regarding you or your family member without you signing an appropriate release of information form.

Client Printed Name: \_\_\_\_\_ Client Signature: \_\_\_\_\_

Parent/Guardian Printed Name(s) (if applicable): \_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature(s) (if applicable): \_\_\_\_\_  
\_\_\_\_\_