David Voorting

Licensed Clinical Social Worker

1535 Killearn Center Blvd., Suite C-1

Tallahassee, Florida 32309

Phone 850-443-1296

Name: _____ Date: _____

Address: _____ Preferred Phone:_____

City_____St_____Zip_____ Alternate Phone: _____

E-mail:_____ Date of Birth_____/_____/_____

Emergency Contact (Parent's name if client is a minor):

Name: _____ Phone:_____

Spouses Name (for couples counseling only) _____

Address (If different) _____ Phone: _____

Email: _____ Date of Birth: _____/_____/_____

How did you hear about me?_____

Primary Care Physician: Name: _____ Phone: _____

Date of last Full Physical Exam: _____/_____/_____

List All Current Medications: _____

List Any Hospitalizations, Major Accidents/Illnesses in the Past 12 Months: _____

_____

_____

By signing below you give your permission for a psychotherapist to test, diagnose, and treat yourself or your minor child identified above. You agree to be responsible for payment at the time services are rendered. **Missed appointments will require full payment from you except in case of emergency.** Please give 24 hours notice to cancel appointments; let your therapist know as soon as possible if you are ill, so the time-slot may be filled. Thank you!

Signature:_X_____Date:_____/_____/_____

Signature:_X_____Date:_____/_____/_____