Pittington Counseling Services

Building Stronger Lives Together
One Step At A Time

CLIENT VITAL STATISTICS

EMERGENCY INFORMATION FORM

DATE OF INITIAL APPOINTMENT:: _____

CLIENT NAME_____
LAST FIRST MIDDLE

SOCIAL SECURITY NO: _____

DATE OF BIRTH: _____**AGE:**_____**SEX:**_____**RACE:**_____**HEIGHT:**_____

WEIGHT:_____**COLOR OF HAIR:**_____**COLOR OF EYES:**_____

ANY DISTINGUISHING MARK(S):_____

SPECIAL MEDICAL PROBLEMS AND ALLERGIES:_____

HOME ADDRESS:_____

CITY: _____**STATE:**_____**ZIP:**_____**COUNTY:**_____

HOME PHONE #:_____**WORK PHONE #:**_____

CELL PHONE #:_____**PAGER #:**_____

EMERGENCY CONTACT NAME : _____

ADDRESS:_____

HOME PHONE #:_____**WORK PHONE #:**_____**CELL:**_____

Do you authorize Pitting Counseling Services to contact your emergency contact in case of a perceived emergency?

(please initial) YES_____ NO_____

REFERRAL SOURCE:_____