



INNER REFUGE COUNSELING

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Inner Refuge Counseling
1700 7th Ave.
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⌘ CONFIDENTIAL CLIENT INFORMATION FORM - ADULTS

Name: _____ Gender (as you identify): _____ Date: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Ok to leave message Text

Home Phone: _____ Ok to leave message

Email: _____ Ok to email

School / Education: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Country of Origin: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Prior Counseling (include names and dates): _____

⌘ MEDICAL

Current / past health concerns: _____

Medications: _____

Have you ever attempted suicide? _____

If yes, please describe. _____

Do you have any current plans to harm yourself? _____

☞ Briefly discuss what brings you to counseling today. Please mention any significant events / challenges that might be related to your visit: _____
