# Restoring Hope Counseling Center

## Of Southern California

dba.rhmsc a 501(c) 3 non-profit corp.

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## CONFIDENTIAL DATA SHEET

Date:_____

NAME:_____
First Last

ADDRESS:_____CITY:_____ZIP_____

PHONE / MESSAGE:_____. Date of birth (MM/DD/YY):___/___/____

IN CASE OF EMERGENCY, CONTACT:_____

PLACE OF EMPLOYMENT:_____OCCUPATION:_____

EDUCATION:_____
MARITAL STATUS: ____M ____S ____DIV ____SEP ___WIDOWED ___ PARTNER

CHILDREN:_____ AGE:_____ LIVING AT HOME? ____

CHILDREN:_____ AGE:_____ LIVING AT HOME? ____

CHILDREN:_____ AGE:_____ LIVING AT HOME? ____

Others living with you?_____

PREVIOUS PSYCHOTHERAPY:
Therapist's name(s):
_____ Dates:_____ # of sessions: ____

_____ Dates:_____ # of sessions: ____
Name of physician:_____
Pertinent medical conditions:_____
Medications being taken:_____
HOW DID YOU HEAR OF OUR SERVICES?_____

PLEASE READ AND SIGN: *I UNDERSTAND THAT IF, FOR ANY REASON, I NEED TO CANCEL AN APPOINTMENT, A TWENTY-FOUR [24] HOUR NOTICE MUST BE GIVEN OR A FULL FEE CHARGE WILL BE MADE.*

SIGNED:_____ DATE:_____