___/____/___
office use only

DBT Counseling Center of Sacramento
Application Form

Client Information:

Name (First, Middle, Last) _____
Street Address_____ Date of Birth _____/_____/_____
City, State, Zip _____
Gender ☐ male ☐ female Email _____@_____
Phone Numbers:
Home _____ Work _____Mobile/Pager _____
Can we leave our name on a recorded message or with someone who answers the phone? ☐ yes ☐ no
Please check the preferred number for us to call.

How did you hear about us?_____

	Emergency Contact Names	Relationship	Phone Number
1			( ) -
2			( ) -

Current Relationship Status:
☐ Single ☐ Separated/Divorced ☐ Committed Relationship (length _____)
Name of Partner _____ Age: _____ Lives in your home ☐

Names of people in household	Relationship	Age

	Psychiatrist	Physician
Name		
Street		
City/Zip		
Phone		
FAX		
Date seen (mm/yr)	from / to /	from / to /

Continue on Reverse Side

Medications (List all current prescription medications)

Drug name	Reason for Prescriptions	Starting Date

Psychiatric Hospitalizations

Month/Year	Days in hospital	Hospital name; City/State

DBT Counseling Center of Sacramento

Release of Information

717 K Street Room 225
Sacramento, CA 95814

I _____authorize the DBT skills group leaders
Print Your Legal Name

Cathy Lieb, LCSW Ph. (916) 705-8961 clieblcsw@yahoo.com LCS17509	Ned Butler, MFT Ph. (916) 662-5744 ned@NedButlerMFT.com MFC41745

to exchange information among themselves and with:

Physician Name: _____

Title: MD, DO, NP or PA _____

Street _____ Room or Suite:_____

City: _____State:____ ZIP: _____

Phone: _____ FAX: _____

Email: _____

Conditions of the Exchange

I am allowing these parties to exchange written or verbal information for one year expiring on ____/_____/_____. The objective of the exchange is to coordinate treatment planning.

Consent Signature _____ Date _____

Printed Name _____

DBT Counseling Center of Sacramento

Release of Information

717 K Street Room 225
Sacramento, CA 95814

I _____authorize the DBT skills group leaders
Print Your Legal Name

Cathy Lieb, LCSW Ph. (916) 705-8961 clieblcsw@yahoo.com LCS17509	Ned Butler, MFT Ph. (916) 662-5744 ned@NedButlerMFT.com MFC41745

to exchange information among themselves and with:

Psychiatrist Name: _____

Title: MD, DO other: _____

Street _____ Room or Suite:_____

City: _____State:____ ZIP: _____

Phone: _____ FAX: _____

Email: _____

Conditions of the Exchange

I am allowing these parties to exchange written or verbal information for one year expiring on ____/_____/_____. The objective of the exchange is to coordinate treatment planning.

Consent Signature _____ Date _____

Printed Name _____