TRINITY COUNSELING SERVICES LLC
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Client Name_____Client Number_____

CLIENT INFORMATION SHEET

Last Name:	First Name:	Middle:	Maiden:
Social Security Number:	Date of Birth/Age:	Gender/Race:	
Address:	City:	State:	Zip:
County:			
Home Telephone:	Cell Telephone:		
Referral Source (name)	E-Mail Address		
Emergency Contact Name: Relation:	Home Telephone:	Cell Phone:	
ADDITIONAL INFORMATION			
Marital Status (circle one): Single (never married) Married Divorced Separated Widowed			
Living Arrangement (family, alone, roommate, significant other):			
Education:	Employer: How long?		
Number of NC DWI's:			
Reason for referral to Trinity Counseling Services LLC			
County of Arrest	Docket Number		
*Driver's License/Customer Number	Breathalyzer Reading		
Arrest Date	Conviction Date		