CLIENT CONTACT INFORMATION SHEET

Schilling Counseling

(509) 426-4581
connerschilling@illuminationtherapyservices.com
Telehealth Services in California and Washington

CONTACT INFORMATION

Name: _____

Birth Date: *(MM/DD/YYYY)* ____/____/_____

Age: ____

Gender: _____

Pronouns: _____

Email: _____

May We Send You An Email?

Yes: ____ **No:** ____

Primary Phone: (____) _____ - _____

Secondary Phone: (____) _____ - _____

May We Leave A Voicemail?

Yes: ____ **No:** ____

Address: _____

City: _____

State: ____ **Zip:** _____

OCCUPATION INFORMATION

Employer:_____

Work Phone: (____) _____ - _____

May We Call this Number?

Yes: ____ **No:** ____

Job Title:_____

Address:_____

City: _____

State: ____ **Zip:** _____

EMERGENCY CONTACT INFORMATION

Name:_____

Relationship:_____

Email:_____

Phone: (____) _____ - _____

May We Call this Number?

Yes: ____ **No:** ____

PLEASE NOTE:

EMAIL CORRESPONDENCE IS NOT CONSIDERED TO BE A CONFIDENTIAL MEDIUM OF COMMUNICATION UNLESS SENT USING AN ENCRYPTED SERVER.