# CLIENT INFORMATION

DAVE KAPLOWITZ, LMFT, CGP

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Name: _____ Date: _____

Date of birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Phone: _____ ☐ Cell ☐ Home ☐ Work ☐ Other: _____

How did you hear about me? _____

Your signature below indicates that you have read the Notice of Privacy Practices and the Client Agreement and agree to abide by their terms during our professional relationship.

Signature: _____ Date: _____