Counseling Solutions KC

Medical Information

Primary Care Physician: _____ Medical Issues: _____

_____

_____

Dosage and length of usage of Medications: _____

_____

_____

Consent for Treatment

I voluntarily consent to treatment for counseling which may include assessment and referral recommendations deemed necessary and advisable in the judgment of my counselor.

Signature of patient or responsible party: _____ Date: _____

Client Concerns

Briefly state how your counselor can help you. _____

_____

_____

Name: _____

Date _____