Hope Behavioral Health, LLC

24100 Chagrin Blvd., Suite 330, Beachwood, Ohio 44122
Phone: 800-642-4560

CLIENT INFORMATION FACE SHEET

Name: ________________________________ ______________________ ____________________________
First Middle Last

Date of Birth: __________________________

Address: ____

Home Phone Number: ____ Preferred: _____

Cell Phone Number: ____ Preferred: _____
(Please check the phone number where you prefer to be contacted)

Email: ____

Appointment Reminders (Check one): Text_____ Email_____ Voice Phone Call_____ All three_____

____________ (Initial): Knowing that standard email and text communication may not be completely secure, I still consent to communications with my therapist and/or other automated appointment reminders through my standard email and texting devices.

Work / Vocation: ____

Emergency Contact: ____ _______________________
Name Telephone

If this number has an answering machine or voicemail, would you like a message to be left? _______

If someone answers the phone, other than Emergency Contact, should a message be left? _________

How did you hear about Hope Behavioral Health, LLC? ____

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ONLY COMPLETE ITEMS BELOW IF CLIENT IS UNDER AGE 18:

Name of Parent or Guardian: ____

Telephone Number of Parent of Guardian: ____

If client is under age 18 and living with someone other than the Parent/ Guardian, complete the following:

Name of Person and/or Foster Parent(s) with whom child is currently residing:

____

Address: ____

Telephone Number: ____