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Client Information Sheet

Client Information:

First Name _____ Initial _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____ (Cell) _____

Date of Birth _____ SS# _____

Relationship Status _____

Current Medical Problems and treatment _____

Current Medications _____

Physician _____

Previous Counseling (Dates) _____

Reason for Seeking Counseling:

Person to Contact in the event of an Emergency _____

Phone _____ Relationship to Client _____

Name of Referral _____

Parent or Person responsible for Payment (if other than yourself)

First Name _____ Initial _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Phone (H) _____ (W) _____

Relationship to the Client: _____