

Lighthouse
Center for Counseling
& Play Therapy, LLC

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Client Information

Home Phone _____ Work Phone _____
Cell Phone _____ Email _____
Address _____ City _____ State _____ Zip _____
Occupation _____ Age _____ Date of Birth _____
Emergency Contact: Name _____ Phone No. _____
Primary Health Care Provider _____ Phone No. _____
Referred by _____ Phone No. _____