

East Bay Family Therapy
Marc Komori Stager, Psy.D.

Biographical Information

Name: _____ Birth date _____
Address: _____ May I correspond with you at this address? Yes/No

Phone Numbers: _____ At this number: May I call? Leave messages?
Home: _____ Yes/No Yes/No
Work: _____ Yes/No Yes/No
Cell: _____ Yes/No Yes/No
Other: _____ Yes/No Yes/No
E-mail: _____ May I communicate with you via e-mail? Yes/No

Who else is living at your home?
Name Age Relationship to you Occupation or school grade

Medical Information

Primary Physician: _____ Phone: _____
Psychiatrist: _____ Phone: _____
Who referred you? _____ Phone: _____

May I thank this person for the referral: Yes/No

May I contact you after therapy is finished for follow-up information and feedback from you? Yes/No

By circling "Yes," and signing below, you consent to allow me to contact you as indicated above, to thank the person who referred you, and to contact you for follow-up and feedback.

Client or guardian's signature

date