

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

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Other helpers in your life

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Other helpers (clergy, counselors, teachers, school personnel, educational consultants, tutors, etc.):

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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