



Jessica Sauer, LCSW  
Brand New Day Counseling, LLC  
1407 E. Robinson Street Orlando, FL 32801  
Phone: (407) 733-5392  
www.brandnewdaycounseling.net

## CLIENT DEMOGRAPHICS

Please provide the following basic identifying information about yourself or the identified client.

Full Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home/Billing Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

May I text you appointment reminders? Circle: Yes or No

Email Address: \_\_\_\_\_

May I email you? Circle: Yes or No

Gender:  Male  Female  Transgender Male  Transgender Female  Gender Queer  Other: \_\_\_\_\_

Sex Assigned at Birth:  Male  Female  Other: \_\_\_\_\_

Pronouns:  She/her/hers  He/him/his  They/them/theirs  Other: \_\_\_\_\_

Medications Taken (if applicable): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parents' Name(s) if Client is a Minor: \_\_\_\_\_

Parents' Marital Status if Client is a Minor:  Single  Married  Divorced  Separated  Widowed

Custody Arrangements/Primary Custodian if Parents are Divorced/Separated: \_\_\_\_\_

\_\_\_\_\_

In case of an emergency, Jessica Sauer may contact (Emergency Contact): \_\_\_\_\_

Emergency Contact's Relationship to Client: \_\_\_\_\_

Emergency Contact's Address and Phone Number: \_\_\_\_\_

\_\_\_\_\_

*This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.*

Signature/Relationship to Client \_\_\_\_\_ Date \_\_\_\_\_

Effective 12/20/2025