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Client Information Form

Name of Client: _____ Date: _____

Name You Would Like to Be Addressed By: _____

Address: _____

_____

Phone: _____
(Home) (Cell) (Work)

May I leave a message at (please check if YES): _____Home _____ Cell _____ Work

Email: _____

May I send you an email message: _____Yes _____ No

Date of Birth: _____ Age: _____
Place of Birth: _____ Gender: _____

Family Information:

Marital Status: Single Domestic Partnership Married Separated Divorced Widowed (circle)

Your religion: _____

Name of Spouse/Partner: _____

Children/Others Living in the Home:

Name(s)	Age(s)

Are you pregnant? _____

Is your mother living? _____ Mother's age: _____
If not, your age at mother's death: _____ Your mother's age at death? _____

Is your father living? _____ Father's age: _____
If not, your age at father's death: _____ Your father's age at death? _____

Number of brothers: _____ Number of sisters: _____

Your position in the family: _____

Employment:

Occupation: _____

Employer: _____

Current Employment:
_____ Full-time
_____ Part-time
_____ Self-employed
_____ Unemployed
_____ Student
_____ Homemaker
_____ Veteran

Education:

Highest level of education attained:

_____ Elementary school
_____ High school
_____ Some college
_____ College graduate
_____ Trade school graduate
_____ Graduate school
_____ Master's degree
_____ Doctorate, JD, or MD

Medical/Mental Health History:

Please list any current medications (Prescription and Over the Counter):

Medication	Dosage	Prescribed by

Primary Care Physician: _____ Phone: _____

Date of Last Physical: _____

Psychiatrist: _____ Phone: _____

Please list any specific medical and/or mental health issues: _____

_____

_____

How would you rate your current sleep habits? How many hours per night do you sleep? _____

_____ Poor _____ Satisfactory _____ Good _____ Very good

How many times per week do you generally exercise? _____

Do you drink alcohol? _____ No _____ Yes _____Daily _____ 1-2 Times/Week _____ Rarely

Are you currently experiencing any suicidal thoughts? _____ Yes _____ No

Have you in the past? _____ Yes _____ No
Have you attempted suicide before? _____ Yes _____ No

Briefly describe the reason you are here/the problem you are experiencing: _____

_____

_____

When did the problem start? _____

_____

How has the problem impacted your life? _____

_____

What do you hope to accomplish during your time in counseling? _____

_____

_____

Referral Source:

How did you hear about me? Referral name:_____

Did you come here voluntarily? _____ Yes _____ No

Emergency Contact Information:

Name: _____Phone: _____

Address: _____

_____

Relationship to You: _____

Thank you for taking the time to complete this client information form. I look forward to talking with you about it during our counseling sessions. Is there anything else you would like for me to know about you?

_____

_____

_____

_____ _____

Client Signature Date

_____

Parent/Guardian Name Printed (if client is a minor)

_____ _____

Parent/Guardian Signature (if client is a minor) Date