

Confidential Client Information

Personal Information:

Today's Date: _____

Last Name: _____ First _____ Middle Initial _____

Address: _____

City: _____ State: _____ Zip _____

Occupation _____ Highest Level of Education _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

Email Address: _____ May I contact you at all of these? _____

Birth Date: _____ Age: _____ Sex: Male _____ Female _____

Relationship status: Single ___ Married ___ In same-sex partnership ___ Widowed ___ Divorced ___

Separated ___ Dating ___ How long? _____ Spouse/partner name: _____

Is your spouse/partner supportive of your seeking counseling? _____

Do you have children? _____ Names/Ages: _____

In case of emergency please notify: _____

Medical History:

Are you currently under medical care? _____ if yes, please indicate reason _____

Physician's Name _____ Phone: _____

Do you take any prescription medications? _____ if so, please list here: _____

Other significant medical history _____

Counseling History:

Have you previously seen a counselor/therapist/psychologist/psychiatrist? _____

Name/Date/Location _____

When was your last appointment with any of the above? _____

Have you ever attempted suicide? _____ Have any family members attempted suicide? _____

Please briefly explain why you are seeking counseling: _____

How long have these concerns been causing you distress? _____

Whom may I thank for referring you to me? _____

How do you hope counseling will help? _____

Is there anything else you would like for me to know? _____

(Please feel free to continue on back if needed)