CLIENT INFORMATION FORM

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Date: _____

Client Name:_____ Date(s) of Birth: _____ Gender: _____

Client Name: _____ Date(s) of Birth: _____ Gender: _____

Parent Name and contact information (if a child)_____

Current Relationship Status (adult only):_____

Mailing Address:_____

Street_____

City _____State _____ Zip _____

Email Address:_____

May we send mail to your home address (we use plain envelopes with only the return address)? Yes_____ No _____
Phone #: (Home) _____May we call you at this #? _____
(Work)_____May we call you at this #? _____
(Mobile)_____May we call you at this #? _____
May we text you at this #?_____

We may set up email or text reminders. Do you give consent to receive email and/or text reminders:_____
How did you hear about our services?_____

Have you previously received professional psychological or psychiatric care? ___ Yes ___No

If Yes, when and with whom?_____

Special Medical Conditions:_____

Current Prescriptions:_____

_____

Children? ___ Living with me (#___) ___ Not living with me (#___) ___ None

Child's Name	Gender	Date of Birth	School Grade
1._____			
2._____			
3._____			
4._____			

Emergency Contact Person not living in your home:

_____

Phone #1: (_____) _____ Relationship to you: _____

Phone #2: (_____) _____ *OK to leave message at these numbers?* ☐ Yes ☐ No

Please check any of the following with which you are currently experiencing difficulty.

_____Alcohol/Drug
_____Alcoholic Parents
_____Anger/Irritability
_____Anxiety/Fear
_____Children's Behavior Problems
_____Concentration
_____Cultural Concerns
_____Depression
_____Eating/Appetite Concerns
_____Family Issues
_____Grief/Loss
_____Parenting
_____Abuse (physical/sexual/emotional)
_____Relationship Concerns
_____Self-esteem/Confidence
_____Sexual Issues
_____Sexual Harassment
_____Stress
_____Suicidal Thoughts/Attempts
_____Trauma
_____other:_____

Please briefly describe what brings you to counseling at this time:_____
_____
_____
_____

In general, how much does this problem bother you?

1	2	3	4	5
Not At All	A Little	Pretty Much	Very Much	Couldn't be worse

What are your goals for counseling?
_____
_____
_____
_____
_____
_____

Is there any other information that may be helpful for your counselor to know?
_____
_____
_____
_____