Client Information Form

Please complete the following information as fully as possible.

PERSONAL INFORMATION Date:_____

Name:_____

Date of Birth:_____ Sex:_____

Home Address:_____

Email Address:_____

Phone (where message can be left):_____

HEALTH INFORMATION

Are you currently under medical care by a physician or psychiatrist? If so, please list whose care and relevant medical conditions:

_____
_____
_____

Please list any medications that you are currently taking:

_____

Have you been to counseling before? If so, when? Please feel free to list any therapy that has been helpful:

_____
_____

FAMILY INFORMATION

Please list name, age, and relationship to you of any family members, partners, or friends that are relevant:

_____
_____
_____

COUNSELING INFORMATION

Please list your specific concerns that you'd like to address in counseling:

_____
_____
_____
_____
_____