CLIENT INFORMATION FORM

Last Name: _____ First Name: _____

Birthdate: _____ Today's Date: _____

Address: _____

Email: _____

Cell Phone: _____ Home Phone: _____

Relationship Status: ☐ Living Together ☐ Married ☐ Separated ☐ Divorced

Profession or
Description of Employment: _____

Level of Education: _____

Prior Relationship
Counseling or Counseling
Experience: _____

If Yes, the Facility/Name of
the Counselor _____

Circle how helpful the counseling was from 1 being not helpful to 5 being very helpful.

1 2 3 4 5

_____ _____

(Print name) (Date of Birth)

_____ _____

(Signature) (Date)