SLADICH COUNSELING

Date Completed: ___________________________

Client Demographics

Last Name: ____

First: ____ Middle: ____

Sex: ☐ Male ☐ Female ☐ Trans ☐ Other DOB: ___________________ Age: _____________

Marital Status: ☐ Single ☐ Married ☐ Separate ☐ Divorced

Street Address: ____

City: ____ State/ZIP: ____

Primary Phone: __________________________________ Can I leave a message for you here? ☐ Yes ☐ No

Work Phone: ____________________________________ Can I leave a message for you here? ☐ Yes ☐ No

Email Address: _______________________________________ Can I leave a message for you here? ☐ Yes ☐ No

If Employed, Employer Information

Employer Name: ____

Occupation: ____ Length of Employment: ___________________________

Street Address: ____

City: ____ State/ZIP: ____

Emergency Contact

Emergency Contact Name: ____

Relationship to Client: ____

Primary Phone: ___________________________________ Work Phone: __________________________________

Street Address: ____

City: ____ State/ZIP: ____

Previous Counseling (Most Recent)

Approx. Start Date: ______________________________ Approx. End Date: ______________________________

Reason for Therapy: ____

____

If ended, why: ____

Practice Type: ☐ Psychiatrist ☐ Psychologist ☐ Counselor ☐ Other/Not Sure

Practice Name: ____

Practice City/State: ____

SLADICH COUNSELING Client Name: ________________________________

Medical

Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No

Psychiatric Medications Prescribed in Last Year: ____

____

Other Medications and Supplements: ____

____

Medical Conditions Relevant to Therapy: ____

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