Client Information Form

Parent Name: _____ Relationship status: _____

Children & others living in household:

Name: _____ Gender: _____ Age: _____ Relationship: _____

Name: _____ Gender: _____ Age: _____ Relationship: _____

Name: _____ Gender: _____ Age: _____ Relationship: _____

Name: _____ Gender: _____ Age: _____ Relationship: _____

Name: _____ Gender: _____ Age: _____ Relationship: _____

Contact information

Home phone number: _____ Work/Other phone number: _____
Check one: □ It is OR □ It is NOT acceptable to call and leave a message at the phone number(s) listed above.

Full address: _____

City: _____ State: _____ Zip code: _____

Occupation: _____

Name of someone to contact in an emergency situation: _____

Full address: _____

Phone number(s): _____

What is your religious affiliation? (circle one)　　Catholic　　Protestant　　Jewish

　　　　　　　　　　　　　　　　　　　　　　　　Mormon　　Muslim　　Hindu

　　　　　　　　　　　　　　　　　　　　　　　　Buddhist　　None　　Other: _____

Please describe any past or current experiences of domestic violence and personal or family history of physical or sexual abuse: _____

_____

_____

Major sources of personal or family strength: _____

_____

_____

_____

Who referred you/How did you learn about Jennifer Moné? _____

_____

Background Information

Have you or your child(ren) had any previous therapy/counseling experience? (circle one)　　Yes　　No

If yes, when? _____

What type of counseling was it? _____

What was helpful about it?　What was not helpful? _____

_____

_____

_____

The #1 reason I am seeking therapy at this time is: _____

_____

_____

Other concerns/problems I am also experiencing include: _____

_____

_____

Who besides you is concerned with this issue? _____

_____

Who else have you consulted with about this concern (i.e., minister, doctor, etc.)? _____

_____

Please list all important events you and your child(ren) have experienced in the last 12 months:

_____

_____

_____

Medical Information

Are you and/or your child(ren) currently experiencing any medical problems?　　Yes　　No

If yes, please explain. _____

_____

Please list any medications you and your child(ren) are currently taking, including psychiatric medications:

Medication	Dosage	Reason for taking

□ Yes □ No　　It is acceptable for Jennifer Moné to send information by mail (such as surveys or other information) during or after our sessions together. *Your name will never be shared with anyone.*