



Take your life to the next level

Heidi Kiebler-Brogan, M.A., LPC, NCC, LMHC

hkbrogan@iecounseling.com

908-456-1871

Client Information Form

Today's date: _____

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Your nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ May we leave a message? _____

Cell Phone: _____ May we leave a message? _____

Email: _____

B. Referral: (Health Professional, News paper, Referral Agency, Friend)

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? • Yes • No

How did this person explain how I might be of help to you? _____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? • Yes • No

D. Your current employer

Employer: _____ Address: _____

Work phone: _____ Calls will be discreet, but please indicate any restrictions: _____

E. Your education and training

Dates		Schools	Special Classes?	Adjustment to school	Did you graduate?
From	To				
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

F. Employment and military experiences

Dates		Name of military or employers	Job title or duties	Reason for leaving
From	To			
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

G. Family-of-origin history

Relative Occupation	Name	Current age (or age at death)	Illness (or cause of death, if deceased)	Education
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Stepparents	_____	_____	_____	_____
Grandparents	_____	_____	_____	_____
Uncles/aunts	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____

H. Relationship history

Are you currently in a relationship? _____

Please share any information you feel is important about your current or past relationship status:

Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First _____	_____	_____	_____	_____
Second _____	_____	_____	_____	_____
Third _____	_____	_____	_____	_____

J. Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

K. Counseling history

Have you been in counseling before: _____ Date(s): _____

Therapist's Name: _____ Address: _____

Reason for therapy: _____

Date of Termination: _____

L. Are you currently taking any medications: (list meds and prescribing doctor):

Any history of mental health hospitalization -when, where, for what:

M. Drug and/or Alcohol use (what, how much how frequent) Include any rehabilitation or self-help groups:

N. Any history of suicidal attempts or thoughts: (when, how often and by what means)

O. Any history of self-harm, cutting: (please describe)

P. Have you experienced any legal issues (please describe-include dates, charges etc.):

Q. Please provide any other information you feel is relative or important to your counseling experience:
