CLIENT INFORMATION FORM
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CLIENT

Name_____ Date of Birth_____

Address_____ City_____State_____Zip_____

Home Telephone (____)_____Cell Telephone (____)_____

Employer_____ How Long? _____

Occupation_____Email address_____

SPOUSE/PARTNER

Name_____ Date of Birth_____

Address_____ City_____State_____Zip_____

Home Telephone (_____)_____Work Telephone (____)_____

Employer_____

Occupation_____Email address_____

MARITAL HISTORY

Current Marital Status: _____married _____ separated _____divorced
_____ single _____ widowed _____ living together
Please give names of persons and dates in any of the following which apply

Date of Marriage(s)_____

Date of Separation(s)_____

Date of Divorce(s) _____

Death(s) of Spouse(s)/Partner(s) _____

Significant Relationships(s) _____

NAME:_____ _____ DATE_____ DATE of BIRTH_____

Marital Status_____

Marriages_____

Seperations_____ _____

Divorce_____ _____

Parents
Mother _____ Deceased_____
Father _____ Deceased_____
Currently _____
Remarried? Mother_____ Father_____

Siblings:
_____one older brother_____

_____

REASON FOR SEEKING COUNSELING

_____

_____

When did you first notice the problem _____

Any major stressors that have recently occurred?, _____

_____

PREVIOUS MENTAL HEALTH TREATMENT _____ _____

_____

SIGNIFICANT FAMILY HISTORY _____ _____

_____

CURRENT MEDICATIONS_____ _____

_____

PARENTS

Mother _____Living? ____yes _____no Resides where? _____

Father _____Living? ____yes _____no Resides where? _____

Currently married to each other/living together? _____yes _____no

Remarried? Mother _____yes _____no Father _____yes _____no

BROTHERS/SISTERS

Name	Age	Lives Where?
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILDREN

Name	Age	Living Where?
_____	_____	_____
_____	_____	_____
_____	_____	_____

EDUCATION

Highest educational degree completed _____ Date _____

Educational major or specialization _____

RELIGION

Religious preference _____

Member? _____yes _____no Active? _____yes _____no

REFERRAL SOURCE

How did you learn about my services?

Name of Person _____

Other (indicate) _____

PREVIOUS COUNSELING

Have you received previous counseling? _____yes _____no Dates_____

From whom? _____

Are you currently being seen by another therapist? If so, who_____ For_____

AGENDA FOR COUNSELING: GOALS

List goals for counseling in order of importance to you.

_____

_____

_____

FAMILY PHYSICIAN

Name _____

Are you on medication? _____yes _____no

If on medication, give name & dosage _____

OTHER INFORMATION

Please add any additional information which you believe may be important for me to know

_____

_____