Individual Form
(to be completed by client)

Date: ______________

Name: ____

Address: ____________________________ City: ______________ Zip: ________

Home Phone: ______________ Cell Phone: ______________ Email: ________________

Referred by: ________________ Address: ______________________________

Occupation: ____________________ Place of Business: ____________________

Work Address: ____ Zip: ________

Work Phone: ____________ Birth Date: ____________ Age: ________ Sex: ______

Is there any other person living in your household? ☐ Yes ☐ No

If yes, please give their names and their relationship to you?

____

____

____

Have you ever been married? ☐ Yes ☐ No If yes, to whom and for long?

____

____

____

Do you have any children? ☐ Yes ☐ No If yes, please list below.

____

____

____

____

Siblings (include biological, adopted, foster, step, etc.):

Name:	Sex:	Age:	Type (bio, step, etc.):	Lived with you?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Are your parents living? Mother ☐ Yes ☐ No Father ☐ Yes ☐ No

If yes, please give their names, address(es), and telephone number(s). If no, give the name, address, and telephone number of the nearest relative.

____

____

COUNSELING HISTORY

From: ____________ To: ____________ With Whom? ____________________

For What? ____

BASIC HEALTH: ☐ Good ☐ Fair ☐ Poor When was your last physical exam? ____________

Who is your Physician? ______________________________

Are you taking any medication at this time? ☐ Yes ☐ No

If yes, what? ____

Are you taking any over the counter medications, herbs , supplements, etc.? ☐ Yes ☐ No

If yes, what? ____

Are you taking any medications for allergies? ☐ Yes ☐ No

If yes, what? ____

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of? ☐ Yes ☐ No

If yes, what? ____

Have you ever been hospitalized? ☐ Yes ☐ No

If so, for what? ____

CURRENT REASON FOR SEEKING COUNSELING:

Briefly describe the problem for which you wish to have counseling?

____

____

____

What would you like to see happen as a result of counseling?

____

____

____

____

The thing which concerns me the most right now is?

____

____

____

IT IS CUSTOMARY TO PAY YOUR THERAPIST AFTER EACH SESSION.

* A Counseling Session is normally 50 minutes.

POLICY

A 24-HOUR CANCELLATION NOTICE IS APPRECIATED; OTHERWISE USUAL FEE WILL BE CHARGED.

I understand that suicidal threats, homicidal threats or child abuse by an adult to a child will be reported.

I understand and give permission to my therapist to seek clinical supervision or consultation about my situation when necessary.

Signature ______________________ Date ______________