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Client Information

Name: _____			Date: _____
<i>First</i>	<i>Middle</i>	<i>Last</i>	
Address: _____			
<i>Street Address</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
Home Phone: _____		Mobile: _____	
At which of these may I leave a message: <input type="checkbox"/> Home <input type="checkbox"/> Mobile <input type="checkbox"/> Email			
Email Address: _____			
Date of Birth: _____		Age: _____	Sex: Female <input type="checkbox"/> Male <input type="checkbox"/>
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Living Together			
Occupation (If Employed): _____		Employer: _____	
School (If Student): _____		Level: _____	
Referred By: _____			
Do I have your permission to release information to the referring professional when appropriate? Y <input type="checkbox"/> N <input type="checkbox"/>			
Emergency Contact: _____		Phone: _____	
Relationship: _____			

- 1) What concerns bring you to counseling?

- 2) What is the history of your present issues?

- 3) What changes do you want to see as a result of counseling?

- 4) What have you tried on your own to resolve your concerns?

Signature of person completing this form: _____

CLIENT BACKGROUND INFORMATION

Name: _____ <i>First Middle Last</i>	Date: _____
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Medical History

Are you currently under a doctor's care? Yes No

Condition for which you're being treated: _____

Date of most recent physical exam? _____ Primary Care Physician: _____

Additional doctor(s) involved in your care:

Current health issues (including allergies): _____

Medications currently in use: No present prescription medications

Medications:	Dosage:	Reason Prescribed:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Vitamins/Supplements currently in use: No present vitamins taken

Family History

Spouse/ Partner:

Name: _____ Occupation: _____
Age: _____ Highest Level of Education: _____

Children: Name Age Sex (Male or Female)

1) _____
2) _____
3) _____
4) _____

Mother:

Name: _____ Occupation: _____
Highest Level of Education: _____ Stepmother: Yes No

Father:

Name: _____ Occupation: _____
Highest Level of Education: _____ Stepfather: Yes Not

Siblings: Name Age Sex: (Male or Female)

1) _____
2) _____
3) _____
4) _____

Signature of person completing this form: _____