



## Client Information

Name of Clinician \_\_\_\_\_

Today's Date \_\_\_\_\_

Referred by \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_ Phone (work/cell) \_\_\_\_\_

E-mail \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex: Male/Female (circle one)

Marital Status (circle one) Married/Single/Divorced/Widowed

Social Security Number \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Relevant Medical conditions (History, current condition, changes in condition)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medication (Name, dosage, name of prescribing professional)

\_\_\_\_\_  
\_\_\_\_\_

Psychiatrist Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Reasons for seeking Counseling (Include any prior history of counseling for mental health, alcohol or drug problems. Use back if necessary)

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_