Confidential Client Information

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Employer:_____ Occupation:_____

Home Phone:_____ Work Ph:_____ Cell Phone:_____

Email address:_____

Birth Date:_____ Age: _____ Gender: Male___ _____ Female_____

Relationship Status: Single_____ Married_____ S-S Paretnership _____ Widow_____ Divorced_____

Separated_____ Dating_____ How Long? _____Spouse's Name:_____

Is your spouse/partner supportive of your seeking counseling?_____

Do you have children?_____ Names/Ages:_____

Who may I thank for referring you to me?_____

Medical History:

Significant medical history:_____

_____

Primary Care Physician:_____ Phone:_____

If you take any prescription medication, please list here: _____

_____

In case of emergency please notify: _____

Goals for our working together:

Please briefly share what you want to get from counseling:_____

_____

_____

_____

Is there anything else you would like for me to know? _____

_____

_____

_____