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CONFIDENTIAL CLIENT INFORMATION

*Welcome to my practice! Please answer the questions to the best of your ability.
The information will help us work together. Thank you.*

Date: _____ E-mail Address: _____

Name: _____
(First) (Middle) (Last)

Address: _____
(Street/PO Box) (City) (State) (Zip Code)

Home Phone: _____ Work Phone: _____ Cell: _____

Date of Birth: _____ Place of Birth: _____

Check One: Single Married/Partnered Long-Term Relationship Widowed

Are you currently a student? Y N If yes, where? _____

Occupation: _____ Employer: _____

Emergency Contact Person: _____ Phone: _____

Who can I thank for referring you to my counseling services?

Please list any ethnic, cultural and/or spiritual background that you would like me to be aware of:

What is your present living situation? (Check all that apply)

Live alone Spouse Partner Children Other

Any allergies I should be aware of? If yes, please list:

Is there a family history of medical problems including mental illness, cancer, heart disease, chronic long-term illness, diabetes, etc.?

Do you have any sleeping problems? Y N

If yes, please describe: _____

How many hours a night do you sleep? _____ Difficulty falling asleep? _____

Do you have any nightmares? Y N How often? _____

Please share your reasons for seeking counseling at this time:

Describe your goals for counseling:

What avenues have you explored to work on them?

Have you had previous counseling/psychotherapy or psychiatric care in the past? Y N

When: _____

With Whom: _____

Upon completion of therapy, what is at least one thing that will tell you therapy was successful?

Please describe your support system and self-care:
