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Confidential Client Information

Personal Information:

Today's Date: _____

Last Name: _____ First _____ Middle Initial _____

Address: _____

City: _____ State _____ Zip _____

Occupation _____ Highest Level of Education _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

But Prefer you contact me at _____ or Email Address: _____

Birth Date: _____ Age: _____ Sex: Male _____ Female _____

Marital Status: Single _____ Married _____ Partnered _____ Divorced _____ Separated _____ Engaged _____

How long _____ If married/partnered, spouse/partner's name: _____

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

Do you have children? _____ Ages: _____

In case of emergency please notify: _____

Medical History:

Are you currently under medical care? _____ If yes, please indicate reason _____

Physician's Name _____ Phone: _____

Do you take any prescription medications? _____ If yes, what are they? _____

Other significant medical history _____

Counseling History:

Have you previously seen a counselor/therapist/psychologist/psychiatrist? _____

Name/Date/Location _____

When was your last appointment with any of the above? _____

Have you ever attempted suicide? _____ Have any family members attempted suicide? _____

In your own words, write why you are seeking counseling: _____

How long have these concerns been causing you distress? _____

By whom were you referred to this counseling center? _____

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How do you hope counseling will help? _____

Is there anything else you feel that is important for the counselor to know: _____
