

# 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 \_\_\_\_\_

Email Address: \_\_\_\_\_ May I contact you at all of these? \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Engaged \_\_\_\_\_

How long have you been in this marital status? \_\_\_\_\_ Spouse's name: \_\_\_\_\_

Is your spouse supportive of your seeking counseling? \_\_\_\_\_

Do you have children? \_\_\_\_\_ Names/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 so, please list here: \_\_\_\_\_

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? \_\_\_\_\_

Please briefly explain why you are seeking counseling: \_\_\_\_\_

How long have these concerns been causing you distress? \_\_\_\_\_

Whom may I thank for referring you to me? \_\_\_\_\_

How do you hope counseling will help? \_\_\_\_\_

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