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Client Information

Client Name: ______________________________ Today's Date: ________________

Address: ____________________ City: ______________ State: _____ Zip: __________

Billing Address: ________________ City: ______________ State: _____ Zip: __________

Date of Birth: __________ Current Age: ______ Email Address: ________________________

Home Telephone: ________________________ Permission to Call: Yes No

Work Telephone: ________________________ Permission to Call: Yes No

Cell Telephone: ________________________ Permission to Call: Yes No

Occupation: ______________________ Employer: ___________________________

Marital Status: Single Married Separated Divorced Cohabitating

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Where did you hear about us? Website Online Search Brochure Friend Other: ______________

Referral Source: Doctor Counselor Pastor Employer Psychiatrist Other: ______________

Name of Referral Source: ____

Are you currently seeing another therapist? __________ If yes, who? ______________________

List any brain injuries, surgeries, or health problems: ______________________________

List any medications you are currently taking (include dose & frequency): ____________________

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What prompted you to make today's appointment for therapy? ____________________________

What have you done about the problem so far? ____________________________________

What do you hope to achieve through counseling? __________________________________