

Client Information Sheet

Today's date: _____

Full Name: _____ Date of Birth: _____

Address: _____

Occupation: _____

Phone: (hm:) _____; (wk): _____; (cell): _____

(Is it OK to leave a message at these numbers for you? _____. If not, how would you like me to contact you? _____)

Email address _____

Spouse/Partner's Name: _____ Date of Birth: _____

If applicable-Children's names and birthdates:

What brings you to counseling at this point in time?

Type of Counseling Requested: _____ (Individual, couple, family, group)

What are your goals for therapy (i.e., if this therapy is successful, what are you hoping will be different in your life)?

What strengths do you have that may assist you in working with these issues?

Previous therapy experience? Yes___ No___ Was it helpful? _____

Issues addressed in previous therapy: _____

Name of previous therapist: _____

Medical: Please list any medications you are currently taking: _____

Any current medical conditions?: _____

Estimated date of last check-up _____

Person to contact in case of emergency (name and phone): _____

How did you hear about me? _____