MARIANNE BINGHAM ROWE, M.S., L.M.F.T

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CLIENT INFORMATION FORM

Name: ______________________________ Date: ____________________

Birthdate: ____________________ Age: ______ Place of Birth: ______________

Address: ______________________ City: ______________ Zip: _______

Who lives in home (name, relationship and age): ______________________________

____

Where employed (client and/or parent): ______________________________

____

Person to contact in case of emergency: __________________ Phone: ____________

Educational information: (If client is child: name of school, principal, teacher, grade)
(If client is adult: highest grade completed; name and location of school)

____

Physician: ______________________ Physical Problems: ________________

______________________ Medications: ________________________

Please check any of the following that apply:

____ Headaches
____ Heart palpitations
____ Shortness of breath
____ Tension and anxiety
____ Depression
____ Fearful/shy
____ Distractible-short attention span
____Unable to relax
____ Difficulty in reading
____ Difficulty in writing
____ Difficulty in math
____ Sexual difficulties
____ Drugs or alcohol
____ Temper outbursts
____ Blackouts
____ Fainting spells
____ No appetite
____ Sleep problems
____ Nightmares
____ Fatigue
____ Easily frustrated

Any major accidents, illness or injuries: ______________________________

Previous counseling: With whom: ____________________ Approximate dates: ______

Summary of previous counseling: ______________________________________

Issues/problems that bring you to therapy now: ______________________________

Referred by: ____