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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: _____ Relationship: _____

Educational information: (If client is under 18 years of age: name of school, 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 ___Unable to relax ___ Heart palpitations ___ No appetite

___ Fainting spells ___ Shortness of breath ___ Tension and anxiety

___ Sleep problems ___ Nightmares ___ Depression ___ Sexual difficulties

___ Fearful/shy ___ Drugs or alcohol ___ Fatigue ___ Temper outbursts

___ Distractible-short attention span ___ 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: _____