Client Information Sheet

Date: _____

Full Name: _____ Nickname: _____

SSN: _____

Sex: _____ Age: _____ Date of Birth: _____

Address: _____

Telephone (Work): _____ (Home) _____ (Cell) _____

Fax: _____

Email: _____

Relationship Status (please circle below):

Married – Separated – Divorced – Widowed – Living w/someone – Single

Length of present relationship (if applicable): _____

Presently Employed: Yes _____ No _____ Occupation: _____

Employer: _____ Part Time: _____ Full Time: _____

Work Address: _____

Referred by: _____ Reason for Referral: _____

Emergency Contact: _____ Relation: _____

Address/Phone of Above: _____

Highest Level of Education: _____ Attending School Now: Yes _____ No _____

Religious Background: _____

Have you ever received Psychotherapy or some form of Counseling? Yes _____ No _____

If Yes, name of Therapist: _____ Dates of Therapy: _____

Issues Addressed: _____

Last Seen: _____ Phone: _____

Therapist Address: _____

Household Members:

Name	Relationship	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Person to Bill (if other than client): _____

Address/Phone of Above: _____

Health Insurance Provider: _____

ID #: _____ Policy #: _____

Group #: _____ Mental Health Coverage: Yes _____ No _____

Reason for visit:

_____

_____

_____

_____

_____

What do you hope to accomplish as a result of this counseling?

_____

_____

_____

_____

_____