The Center for Well Being

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CLIENT INFORMATION FORM

(Note: This information will be kept in confidence)

□ New client □ Returning client

Name of Client: _____ Today's Date:_____
Name You Would Like to Be Addressed By:_____
Address:_____
_____
Phone:(Home) _____(Cell)_____ (Work)_____
May I leave a message at (please check if YES): Home _____ Cell _____ Work _____
Email:_____
May I send you an email message/information about events: Yes _____ No _____
Date of Birth: _____ Age: _____
Place of Birth: _____ Gender: _____

Briefly describe the reason you are here/the problem you are experiencing:
_____
_____
_____ _____
_____
_____ _____

When did the problem start?
_____
_____
_____

How has the problem impacted your life?
_____
_____
_____

Have there been times in your life when this problem did not affect you? yes ___ no ____

If yes, please tell me when that was:
_____
_____

What were you doing in your life at that time, and who else might have known about this?
_____
_____
_____
_____

What are your hopes for yourself and for your life more generally?

_____
_____
_____
_____

What do you hope to accomplish during your time in counseling?

_____
_____
_____
_____
_____

Family Information:

Composition of Present Household (check all that apply):

Living alone _____ Living w/ Parent _____ Living w/ Spouse____
Living w/ Romantic Partner _____ Living w/ In-Laws _____
Living in Group House _____ Living w/ roommate _____
Other (please describe)_____
Name of spouse/partner_____

Number of children: _____
Ages: _____
Number of children living: _____ Deceased: _____
Number of children in household: _____

FAMILY

Is your mother living? _____ Mother's age: _____
If not, your age at mother's death: _____ Your mother's age at death: _____
Is your father living? _____ Father's age: _____
If not, your age at father's death: _____ Your father's age at death: _____

Number of Brothers: _____ Number of Sisters: _____
Your Position in the Family:
Eldest _____ Middle _____ Youngest _____
Twin _____ Adopted _____ Only child _____
Are all of your siblings living? (if not, your age at sibling's death(s) & please explain.)

_____
_____
_____

Education

Your highest education level attained (check one):

Elementary school	_____	Trade school graduate	_____
High school	_____	Graduate school	_____
Some college	_____	Master's Degree	_____
College graduate	_____	Doctorate, J.D. or M.D.	_____

Employment

Occupation: _____

Current Employment:	Fulltime	_____	Part-time	_____
	Self-employed	_____	Unemployed	_____
	Student	_____	Homemaker	_____
Current Income:	_____		Are you a veteran?	_____

Medical/Mental Health

Personal Physician: _____
Address: _____
Phone: _____
Date of last physical: _____

Medical Conditions: (past/current):

_____

_____

Are you taking any medications?
If so, what types? _____

_____

Previous mental health or emotional issues: _____

_____

_____

Have you been to therapy before? ____yes ____no
If yes, when _____
What issue(s) did you address? _____

Referral Source:

How did you hear about me? Referral name:_____

Emergency Contact Information:

Name: _____Phone: _____

Address:

_____

_____

____

Relationship to You: _____

Thank you for taking the time to complete this client information form. I look forward to talking with you about it during our counseling sessions. Is there anything else you would like for me to know about you?

_____

_____

_____

_____ _____

Client Signature _____Date _____

_____

Parent/Guardian Name Printed (if client is a minor)

_____ _____

Parent/Guardian Signature (if client is a minor)_____

Date_____