



Date \_\_\_\_\_

File \_\_\_\_\_

### **Confidential Client Information**

*(Please print clearly.)*

Full Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Full Address: \_\_\_\_\_

Preferred phone: \_\_\_\_\_ Alternate: \_\_\_\_\_

Permission to leave voice mail? Yes/No Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Length of Employment: \_\_\_\_\_

Referral Source: \_\_\_\_\_

#### Education

Grade completed: \_\_\_\_\_ High School Diploma? Yes/No

Business/Technical School: Area of study \_\_\_\_\_ Certificate? Y/N

College (circle): 1 2 3 4 Degree \_\_\_\_\_

Graduate School: 1 2 3 4 Degree \_\_\_\_\_ Area of Study \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_

Number: \_\_\_\_\_ Relation to you: \_\_\_\_\_

Relationship Status: *(Please circle)*

Single      Married      Committed Partnership

Separated      Divorced/Divorcing      Widowed

#### Medical Information

Do you have any current medical problems? If so, please explain:

\_\_\_\_\_

\_\_\_\_\_

Do you take regular medications? \_\_\_\_\_ (If so, please list on back if needed.)

\_\_\_\_\_

Do you smoke? Yes/No    How much? \_\_\_\_\_    How long? \_\_\_\_\_

Have you ever received help for drug or alcohol issues?    Yes/No

Has a family member received help for drug or alcohol issues? Yes/No

If yes, relation to you? \_\_\_\_\_

#### Previous Therapeutic Services

Have you ever received counseling or psychotherapy?    Yes/No

Was it helpful? Yes/No    If yes, how? If not, why not? \_\_\_\_\_

\_\_\_\_\_

Have you received assistance from other healing modalities? Yes/No

If so, what has been helpful? \_\_\_\_\_

\_\_\_\_\_

#### Current Situation

Please describe your reasons for seeking assistance at this time:

\_\_\_\_\_

\_\_\_\_\_

What are you hoping for (as a result of our working together)?

\_\_\_\_\_

\_\_\_\_\_

Current support system: \_\_\_\_\_

\_\_\_\_\_

Current stressors: \_\_\_\_\_

Any additional information you'd like to share: \_\_\_\_\_

\_\_\_\_\_