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Client Information Sheet for Adults and Couples

Name: _____
Address: _____
City: _____ Zip: _____
Date of birth: _____ Age: _____
Occupation: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____

Name: _____
Address: _____
City: _____ Zip: _____
Date of birth: _____ Age: _____
Occupation: _____

Home Phone: _____
Work Phone: _____
Cell Phone: _____

Emergency contact:

Name: _____
Address: _____ City: _____ Zip: _____
Phone number: _____ Relationship to you: _____

Marital status:

☐ Single ☐ Married ☐ Separated ☐ Widowed
☐ Cohabitating ☐ Remarried ☐ Divorced ☐ Engaged

Children and step-children:

Name: _____ Age: _____ ☐ Child ☐ Step-child
Name: _____ Age: _____ ☐ Child ☐ Step-child
Name: _____ Age: _____ ☐ Child ☐ Step-child
Name: _____ Age: _____ ☐ Child ☐ Step-child
Name: _____ Age: _____ ☐ Child ☐ Step-child
Name: _____ Age: _____ ☐ Child ☐ Step-child

Health insurance coverage:

Name of insurance company: _____ Phone: _____
Plan or policy #: _____ Certificate # _____ Individual ID: _____
Name of insured if different than client: _____

Medication:

Name/dosage: _____ Prescribed for: _____ Doctor: _____
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Current goals and concerns (list your reasons for coming to counseling):

1. _____
2. _____
3. _____
4. _____

Indicate each of the stressors you or others have experienced during the last six months:

- ☐ Loss of job
- ☐ Hospitalization
- ☐ Stopped smoking
- ☐ Pregnancy
- ☐ Retirement
- ☐ Suicidal thoughts
- ☐ Suicide attempts
- ☐ Sexual difficulties
- ☐ New family member
- ☐ Feelings of worthlessness
- ☐ Panic or anxiety attacks
- ☐ Death of a close friend
- ☐ Death of close family member
- ☐ Financial difficulties
- ☐ Arrest or pending charges
- ☐ Incarceration/ conviction
- ☐ Major accident/injury/ illness
- ☐ Involved in lawsuit
- ☐ Increase in number of arguments
- ☐ Outstanding personal achievement
- ☐ Anger management problems
- ☐ Other self-control problems
- ☐ Alcohol or drug problems
- ☐ Significant weight loss/ gain
- ☐ Significant changes in memory or attention

Have you recently experienced any major changes in:

- ☐ Empty nest
- ☐ Eating habits
- ☐ Social activities
- ☐ Living arrangements (moved)
- ☐ Family responsibilities
- ☐ Work responsibilities
- ☐ Sleeping habits
- ☐ Exercise habits
- ☐ Other:_____

Previous counseling or therapy:

- ☐ Individual
- ☐ Couple
- ☐ Family
- ☐ Group
- ☐ Outpatient
- ☐ Inpatient
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ MFT
- ☐ LPCC
- ☐ LCSW
- ☐ Other:_____

Name of provider: _____How long?_____
Reason for treatment: _____Results:_____

I have answered these questions to the best of my knowledge.

Client signature: _____Date:_____

Client signature: _____Date:_____