Client Information Sheet

Last name:			First name:	
Date of birth:	Month	Day	Year	Age
Street address:			City:	
Zip code:				

May I send mail to your home address? ☐Yes ☐ No

Home phone: ( )	Call you at home? ☐Yes No☐ Leave a message at home? ☐Yes No☐
Cell phone: ( )	Call you on your cell? ☐Yes No☐ Leave a message on your cell? ☐Yes No☐

Email address:

May I communicate with you via email? ☐Yes No☐

List the members of your immediate family and/or others presently living in your home:

Name:	Age:	Relationship to you:

Name of person to contact in emergency:	Their relationship to you: Home phone: ( ) Cell phone: ( )

Employment status: ☐Full time ☐Part time ☐Unemployed ☐Disability ☐Retired

If you are a student ☐Full time ☐Part time Name of school:

Have you had previous counseling? ☐Yes ☐No

Name of provider: Number of sessions:

When:

Referred here by:

Have you been hospitalized for mental illness? ☐Yes ☐No

If yes, please list where, when, for how long, and for what reason.

If you were referred by your doctor may I have your permission to inform him/her that you have consulted me? ☐Yes ☐No

If yes:

Doctor's name:

Address:

Phone number:

Signature:

Date: