Client Information

Client name: ____ Date:_____________

Parent/Legal Guardian (if client a minor): ____

Address:

____

Email Address:

____

Phones: (H): ____________________ (C): ____________________ (Wk): ____________________

Date of Birth: ___________________________ Marital Status: _________________________

Client Occupation: _______________________ Last Grade Completed: ___________________

Medications Used Regularly: ____

Reason(s) you are seeking therapy?

____

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What you would like to see happen as the result of therapy?

____

____

What strengths do you have that will help make this happen?

____

Previous Counseling/Therapy (When? Helpful or Not?):

____

____

Please check any of the following that are applicable:

Anxiety/Worry ___	Depressive Thoughts ___	Self Esteem Issue ___
Sexuality Issue ___	Substance Use ___	Sleep Disruption ___
School Issue ___	Anger Management ___	Eating Issue ___
Stress ___	Internet Addiction ___	Sex Addiction ___
Self Harm ___	Relationship Issue ___	Parenting Issue ___

Trauma History___ Explain: ____

____

Other Concerns: ____

Please let me know any other information that might be useful in helping me assist you.

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Thank you for providing this information for me. I look forward to learning more about you and your story, and us working together to meet your goals.