CLIENT INFORMATION – *IF CHILD, PLEASE GIVE CHILD'S INFORMATION*

General Information:

Date: _____Client Name _____
Last First Middle

Address: _____ City, State, Zip _____

Phone: ( ) _____ Date of Birth: _____ Age _____ Sex _____

Client's Social Security: _____

Marital Status: Never Married _____ Married _____ Separated; if yes, how long? _____

Divorced; if yes, how long? _____ Remarried? _____ Total # of marriages _____

Spouse's Name: _____ Age: _____ Occupation: _____

Who has custody of children? ____ Mother ____Father _____Both Parents _____Other

Insurance Information:

Primary Insurance: _____ Name of Insured: _____

Insured's Social Security: _____ Insured's Date of Birth: _____

Employer: _____ Policy Number: _____

Group Number: _____ Contact to Verify Benefits: ( ) _____

Claims Address: _____

Secondary Insurance? ____ Yes ____No

Client Information:

Living Arrangements: _____

Race: Alaskan Native/American Indian/Asian, Pacific, Islander/Black/White/Other
Ethnicity: Puerto Rican/ Mexican/ Cuban/Other/Unknown

Veteran: Yes/No Receiving Benefits: Yes/No Active in the Military: Yes/No

Disability: None/Blind/MR/DD/Deaf/Mute/Non-Ambulatory/Neurological Problems

Medications: (Please List) _____

Do you have any medical problems? _____

Education: (Total Number of Years Completed) _____

Employment Information:
Employer's Name: _____ Occupation: _____

Phone: ( ) _____ Status: Full Time/Part Time/Unemployed/Not in Labor Force

Referrals: Who Referred You? _____ May I Contact Them? ___Yes ___No
Past counseling experience? ___Yes ___No If yes, for what reason?_____

When/how long? _____ Previous Counselor: _____

Have you ever been hospitalized in a mental health facility? ___Yes ___No

Where, when and for how long? _____

School Information: (To be completed for child client):
School Name: _____ Contact Person: _____

Address: _____ Telephone Number: ( ) _____

Family Physician Information:
Physician's Name: _____ Address and Phone: _____

Psychiatrist's Name: _____ Address and Phone: _____

Emergency Contact and Responsible Party:
Emergency Contact: _____ Telephone Number: ( ) _____

Relationship to Client: _____ Responsible Billing Party: _____

Address: _____ Relationship to Client: _____

Financial Information:
Total Household Income per Year: _____ Number of Family Members: _____

Religious Affiliation:
Organized religion? ____ Yes ____No To which one do you belong? _____

Record of Mother's Information:
Name: _____ Address: _____

Home/Work Phone: ( ) _____( ) _____ Employer: _____

Record of Father's Information:
Name: _____ Address: _____

Home/Work Phone: ( ) _____( ) _____ Employer: _____