Client Information

Name: _____ _____

(Last) (First)

Address: _____

_____

_____

Phone: _____ **Okay to leave a message?** Yes No

E-mail: _____

Date of Birth: ___ / ___ / _____

Occupation: _____

Are you currently taking any medications? If yes, please list below:

_____ _____ _____

_____ _____ _____

Date of last doctor's visit (Month / Year): _____ / _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Reason for requesting therapy (circle any that apply):

Depression Anxiety Autism Spectrum Issues Relationship Issues Food Issues

Anger Other: _____

OVER

Have you been to counseling before? Yes No

Prior Diagnoses: _____

Do you use any recreational drugs? Yes No **Type:** _____

How many alcoholic drinks do you have per week? None 1-3 4-6 6-10 10+

Imagine that somewhere down the road, you decide to end counseling because you feel better; your life is different. How would your life be different?

_____

_____

_____

_____

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