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CLIENT INFORMATION

Name _____ Date of Birth _____

Address _____

Home Phone _____ Single Married Partner Divorced (circle one)

Work Phone _____ Cell Phone _____

Occupation _____ Employer _____

Referred by _____

Have you been in therapy before? _____ If so, please list names of therapists or counseling professionals that have seen you, as well as the dates of services, as well as what was or was not helpful in your previous therapy experience. _____

My primary concern for treatment at this time is _____

When did you first notice that you were experiencing problems, and what brings you to therapy now:

Please list any medications that you are currently taking and for how long

What are your goals for treatment at this time?

Describe any family, occupational or social stressors that may be contributing to your current problems or level of functioning

Is there any other information that you would like to share? _____

