Confidential Client Information

Personal Information: **Today's Date**:_____

Last Name:_____ First:_____ Middle: _____

Address:_____

City: _____ State: _____ Zip:_____

Occupation:_____

Phone Number(s): _____(H,C,W), _____(H,C,W)

Birth Date:_____ Age:_____ Sex: Male_____ Female_____

Marital Status: Single_____Married_____Divorced_____Separated_____Engaged____

If married/partnered, spouse/partner's name:_____

Are they supportive of you seeking counseling: _____

Children?_____ Ages: _____

In cases of emergency please notify: _____

Medical Information:

Are you currently receiving medical care? _____ If yes, indicate reason:

_____

Physicians Name: _____ Phone: _____

Do you take any prescription medications?_____ If yes, what are they?

_____

Counseling History:

Have you previously seen a counselor/therapist/psychologist/psychiatrist?_____

Name/Date/Location:_____

Have you ever attempted suicide? _____ If yes, when? _____

Why are you seeking counseling currently? _____

_____

_____

How long have you had these concerns? _____

How did you hear about Joyful Living Family Counseling? _____

How do you hope counseling will help? _____

_____