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Client Information

The following information will assist me in more fully understanding your life and your history.

Date: _____ Legal Name: _____ Name you go by: _____

Pronoun (he, she, they...): _____

Home Address: _____

Phone: _____ Email address: _____

Emergency contact/relationship to you: _____ Phone: _____

Any special requests, if I need to contact you (i.e. not disclosing my identity on voicemail): _____

DOB: _____ Age: _____ Occupation: _____

Served in the Military? _____ If so, when? _____

Marital Status: _____ If married, spouse's name: _____ # years married: _____

If not married, are you in a relationship(s)? _____ For how long? _____

Partner's(s') name(s): _____

Do you live together? _____ If so, for how long? _____

Do you have children? _____ If so, do they live with you? _____ Names and ages: _____

List any medications you are taking and what they are for:

Allergies?

Name of family physician (if you have one):

Name of psychiatrist (if you are seeing one):

How did you learn about my services?

What influenced your decision to seek a counselor at this time?

Please describe any previous counseling experience:

What do you hope to achieve through this counseling experience?

Insurance: please bring your insurance card to your initial appointment

Subscriber ID# _____

Other information you would like me to have: _____