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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: \_\_\_\_\_ Place of birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer or School Name: \_\_\_\_\_ 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: \_\_\_\_\_