Jenny Shealy, LCSW

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:_____
_____
_____
_____
_____