CONFIDENTIAL INFORMATION

Today's Date _____Referred by_____

Name_____ DOB_____ Age_____

Address_____ City_____ Zip Code_____

Day Phone_____Ok to call? __ Y _N/ Eve. Phone_____Ok to call? _Y _N

Cell Phone_____ Email _____

Marital Status: _____Single ____Married ____Divorced _____Remarried ____Widowed

Spouse's Name (if applicable) _____DOB_____ Age_____

Any Children? ___Yes ___No If yes, please list names and ages:_____

_____

What is your work?_____ Average annual income?_____

Is spirituality/religion important to you? ___Yes ___No If yes, briefly describe _____

_____

Are you currently taking any medication? __Yes __No If yes, please list and for what purpose:

_____

_____

Have you received counseling before? __Yes __No If yes, please describe when, for what purpose and with whom: _____

_____

Who is your medical doctor?_____ Phone_____

In case of emergency, call? _____ Phone_____

How would you describe your health? _____

Describe any recent changes and/or losses you have experienced over the past year:

_____

_____

How can counseling help you at this time? _____

_____

_____

What do you see as the problem or needed change? _____

_____