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202-335-3119

Client Information Form

Client Name: _____ **Today's Date:** _____

Preferred Name: _____ **Date of Birth:** _____

Home Address: _____

Phone (please list as many numbers as you wish, in order of preference. Do not list any numbers at which you do not wish to be contacted): _____,

_____, _____.

Occupation: _____ **Employer:** _____

If employed, how long have you been at your present job? _____

Who may we contact in case of emergency? Please list name, relationship and phone number: _____

Reason(s) for seeking counseling at this time: _____

_____

_____

_____

Current Relationship Status (check one):

____ Single ____ Married (anniversary) _____

____ Live-in relationship (length of time) _____

____ Non-live in relationship(s) (length of time) _____

____ Separated (date); _____ ____ Divorced (date) _____

____ Widow(er) (date) _____

Spouse/Partner Name (if applicable): _____ **Age:** _____

Spouse/Partner Name (if applicable): _____ **Age:** _____

Occupation/Employer of Spouse/Partner: _____

Occupation/Employer of Spouse/Partner: _____

Previous Marriages/Live-in/Significant Relationships:

1. From _____ to _____ 2. From _____ to _____

3. From _____ to _____ 4. From _____ to _____

5. From _____ to _____ 6. From _____ to _____

Children (include stepchildren, foster children, adopted children):

	Name	Gender	Age	Place of Residence
1.	_____	_____	____	_____
2.	_____	_____	____	_____
3.	_____	_____	____	_____
4.	_____	_____	____	_____
5.	_____	_____	____	_____

In what religion, if any, were you raised? _____

What, if any, is your religious preference: _____

Where did you live for the first 15 years of your life? (city and state): _____

_____

Are your parents living together? ____ Yes ____ No, because of _____ (death, divorce, etc)

If parents are not living together, is either remarried or in a committed relationship?

____ Yes (if yes, which parent and for how long?) _____

____ No

Siblings (include stepsiblings, half sibling, etc.)

	Name	Gender	Age	Place of Residence
1.	_____	_____	____	_____
2.	_____	_____	____	_____
3.	_____	_____	____	_____
4.	_____	_____	____	_____
5.	_____	_____	____	_____

Family Mental Health History:

	Relative	Diagnosis	Year
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

5. _____ _____ _____

Family Substance Abuse History:

	Relative	Length of Time	Current?
1.	_____	_____	Yes No
2.	_____	_____	Yes No
3.	_____	_____	Yes No
4.	_____	_____	Yes No

Personal Health Issues:

	Diagnosis	Year	Medications Taken (include dosage/frequency)
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Please list any additional medications that you take more than one time per week: _____

_____

Previous Hospitalizations:

	Reason/Diagnosis	Year
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Previous Counseling Experiences:

	Type (individual, couples, family)	Year	Name of Counselor
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____