COUNSELING CLIENT INFORMATION FORM TEMPLATE

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DATE	ADMINISTRATOR

IS THIS A PREVIOUS PATIENT?	REFERRED BY

PATIENT INFORMATION

NAME		**HOME ADDRESS**	
CELL PHONE			
ALT. PHONE			
EMAIL		**WORK ADDRESS**	
SOC SEC #			
DATE OF BIRTH			

EMERGENCY CONTACT

NAME OF CONTACT		**RELATIONSHIP TO CLIENT**	
MAIN PHONE #		**ALT. PHONE #**	

HEALTH INFORMATION

Describe the reason for the initial visit.

Describe your mental health in general.

Please circle any of the following conditions you've had a health issue with.

anxiety	parents	self-inflicted pain	broken bone
depression	children	financial problems	measles
anger	sleeping	head injuries	hepatitis
concentration	child	nausea	tuberculosis
phobias	abuse	attention	neck pain
communication	sex abuse	trust in others	diabetes
drugs/alcohol	nightmares	worry	artificial joints

Please specify on any conditions circled above.

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