Date: _____

CLIENT 1		CLIENT 2	
Name:		Name:	
Date of Birth/Age:		Date of Birth/Age:	
Home Address:		Home Address:	
City, State, Zip:		City, State, Zip:	
Home Phone:		Home Phone:	
Cell:		Cell:	
Employer:		Employer:	
Work Phone:		Work Phone:	

May I call you and leave messages at home? Yes ☐ No ☐ On your cell? Yes ☐ No ☐ At Work? Yes ☐ No ☐

Marital status: S ☐ M ☐ D ☐ W ☐ LT ☐ Married how long? _____ Previously Married? Yes ☐ No ☐

If divorced with joint custody, how is decision making around health matters arranged? _____

Children:			
	Date of Birth/Age		Step/Bio/Adopted
	Date of Birth/Age		Step/Bio/Adopted
	Date of Birth/Age		Step/Bio/Adopted
	Date of Birth/Age		Step/Bio/Adopted
	Date of Birth/Age		Step/Bio/Adopted

MEDICAL HISTORY

Any current physical problems or medical problems (e.g. headaches, body aches, stomach problems)? Yes ☐ No ☐

If yes, please explain: _____

Please list any learning disabilities: _____

COUNSELING AND PSYCHIATRIC HISTORY

Have you had previous counseling? Yes ☐ No ☐ If yes, when? _____ Name and location of counselor: _____

If yes, for what reason? _____ For how long? _____

Have either of you ever been diagnosed with or treated for any type of mental illness? Yes ☐ No ☐

If yes, what? _____

Has anyone in your family been diagnosed with or treated for any type of mental illness? Yes ☐ No ☐

If yes, what? _____

MEDICATION(S)	DOSAGE

REASONS FOR SEEKING HELP

What concerns have brought you to counseling today? _____

What do you hope you will gain from counseling? _____

EMERGENCY CONTACT (Next of Kin – Other than Spouse)

Name: _____ Relationship: _____

Home Phone: _____ Cell: _____

Address: _____ City, State, Zip: _____