Client Application

Today's Date
Name Date of Birth
Address City State Zip
Cell Phone ( ) Work Phone ( ) Home Phone ( )
Calls will be discreet, but please indicate any restrictions:
Email address:
Occupation: Spouse's Occupation:
Emergency Contact Person: Phone:
Relation to you: Address:

FAMILY INFORMATION

Relationships:
☐ Single ☐ Engaged ☐ Married ☐ Cohabitating
☐ Separated ☐ Divorced ☐ Widow (er)

Spouse's Name

Do you believe your marriage contributes to the problem that brings you to this counseling assessment?
☐ Yes ☐ No

Please List All Who Are Living in Household:

Name	**Relationship**	**Age**

MEDICAL INFORMATION

How would you describe your health?
Has there been any change in your weight this past year? ☐ Yes ☐ No If yes, please explain:

Has there been any change in your sleep patterns this past year? ☐ Yes ☐ No If yes, please explain:

Physician Name Physician Address:
Physician Phone: ( )

When was your last medical exam?
Current medications & for what purposes taken

Have you or any member of your family ever received or considered seeking help for drug or alcohol dependency?
☐ Yes ☐ No Dates Name of Professional/Agency

Does alcohol or any form of drug or medication contribute to your present concerns? ☐ Yes ☐ No

COUNSELING BACKGROUND

Have you had counseling in the past?
☐ Yes ☐ No Dates By whom?

For what purpose?

Who referred you to my practice?

Type of Therapy Desired: ☐ Individual ☐ Marital ☐ Family ☐ Group

Religious Preference Local Congregation

Please list your strengths, hobbies, and interests:

Please describe your reason(s) for seeking assistance now

What would you like to have happen for you as a result of therapy?

How likely are you to complete homework assignments and other work required of you in between sessions to help yourself feel better? Please circle one: ○ ***Very Likely*** ○ ***Somewhat Likely*** ○ ***A Little*** ○ ***Not at all***

I have read the disclosure statement and understand that I have the opportunity to ask any questions.

Signature Date
Counselor Date