



GENERAL INFORMATION

Name: _____ Birthdate: ____/____/____

Address: _____

City: _____ Zipcode: _____

Home Phone:(____) _____ Business/Cell Phone:(____) _____

Email (Please Print Clearly): _____

School (if minor): _____ Counselor: _____

Employer Name: _____

Position: _____ No. of Years: ____ Annual Household Income: _____

Members of Household (Names)	Relationship to You	Age
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe any legal action you may have taken or which may have been taken against you for any reason at any time _____

Briefly describe any health problems or physical symptoms you may have _____

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

Previous Counseling Experiences: Date _____ to _____ Counselor: _____

Reason(s) for seeking services then: _____

Please list any medications you are currently taking, who prescribed them, and why:

Please list any drugs or alcohol you use: _____

Frequency/amount of consumption: _____

Have you ever seriously considered or attempted suicide? yes / no When? _____

Client Signature: _____

Parent/Guardian Signature: _____