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# INDIVIDUAL CLIENT INFORMATION FORM

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

**Address:** _____

**Telephone: (cell)** _____ **OK to leave message? Yes __ No__**

**Telephone: (home/work)** _____ **OK to leave message? Yes ___No___**

**Email address** _____

**Date of Birth:** _____ **Age:** ____ **Gender:** _____

**Occupation:** _____ **Education:** _____

**Relationship Status:** Single____ Partnered____ Married____ Divorced___ Widowed____

**Name and number of person I can contact in case of emergency:** _____

**Please list the current members of your household:**

| **Name** | **Age** | **Relationship to You** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**If you have had previous counseling or therapy, briefly describe this experience (when, with whom, and why you sought help).**

_____

_____

_____

_____

**Briefly describe your reason(s) for seeking counseling:**

_____

_____

_____

_____

_____

**Please list any medical problems or physical symptoms. _____**

_____

_____

**Please list any medications that you are currently taking.**

**Name of medication Dose Taken for: Prescribed by:**

_____

_____

_____

_____

**Have you thought about hurting or killing yourself within the past 6 months? No__ Yes___**

**Have you ever attempted suicide? No___ Yes___ If Yes, when? _____**

**What do you consider your strengths? _____**

_____

_____

_____

**How did you learn about my services? _____**

***Thank you for completing this form.  Barbara A. Segal, LPC, NCC, CHT***