Client Information Form

Please read and complete all information requested. **Date: _____**

Name: _____

Address: _____

City, State and Zip: _____

Social Security Number: _____

Home Phone: _____ **Work Phone: _____**

Cell Phone: _____ **E-mail: _____**

If client is a minor: Parent/Guardian_____Phone:_____

Preferred way to contact you: Home ____ Work ____ Cell____ E-mail ____

Preferred phone number for receiving session reminder calls (check one):

Home_____ Work_____ Cell_____

Birth date: _____ Age: _____ Gender identity _____

Single ____ Married _____ Divorced ____ Separated _____ Widowed _____ In a relationship ____

Ethnicity (please circle): African-American Caucasian Hispanic

Multi-racial Asian Other (please indicate): _____

Who referred you? _____

Religious Affiliation (if any): _____

Occupation and Employer: _____

Student: Full-time _____ Part-time _____

Please state briefly your reason for seeking counseling: _____

_____

_____

_____

Other information your therapist might find helpful: _____

_____

_____

Self-Description Checklist (Please check all that apply):

__ angry	**__ hopeless**	**__ fatigued**	**__ confused**
__ energetic	**__ suicidal**	**__ resentful**	**__ irritated**
__ ambitious	**__ dangerous**	**__ unhappy**	**__ depressed**
__ happy	**__ lonely**	**__ violent**	**__ sleep problems**
__ inadequate	**__ marital conflict**	**__ parent conflict**	**__ work stress**
__ anxious	**__ isolated**	**__ fearful**	**__ bereaved**
__ guilty	**__ ashamed**	**__ cheerful**	**__ optimistic**
__ distrustful	**__ apathetic**	**__ hurt**	**__ numb**
__ abused	**__ loss of appetite**	**__ worried**	**__ panic**
__ hopeful	**__ jealous**	**__ indifferent**	**__ poor sex drive**

Hillcrest Therapy Center

__ faith issues __ overeating __ drug use/abuse __ alcohol abuse

__ fretful __ unwelcome thoughts

Are you currently taking any medications, prescription or over the counter? _____ Yes _____ No

If yes, specify type, dose and reason for taking: _____

_____

_____

_____

_____

If prescription, who prescribed them? _____

_____

Please fill in the following information for any 3rd party that will be responsible for client payments (This section is required for clients who are minors)

First Name: _____ Last Name: _____

Address:_____

City, State and Zip: _____

Emergency Contact & Phone: _____

Medical Concerns: _____