Individual Form
(to be completed by client)

Date: _____

Name: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Referred by: _____ Address: _____

Occupation: _____ Place of Business: _____

Work Address: _____ Zip: _____

Work Phone: _____ Birth Date: _____ Age: _____ Sex: _____

Is there any other person living in your household? ☐ Yes ☐ No

If yes, please give their names and their relationship to you?

_____

_____

_____

Have you ever been married? ☐ Yes ☐ No If yes, to whom and for long?

_____

_____

_____

Do you have any children? ☐ Yes ☐ No If yes, please list below.

_____

_____

_____

_____

Siblings (include biological, adopted, foster, step, etc.):

Name:	Sex:	Age:	Type (bio, step, etc.):	Lived with you?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Are your parents living? Mother ☐ Yes ☐ No Father ☐ Yes ☐ No

If yes, please give their names, address(es), and telephone number(s). If no, give the name, address, and telephone number of the nearest relative.

_____

_____

COUNSELING HISTORY

From: _____ To: _____ With Whom? _____

For What? _____

BASIC HEALTH: ☐ Good ☐ Fair ☐ Poor When was your last physical exam? _____

Who is your Physician? _____

Are you taking any medication at this time? ☐ Yes ☐ No

If yes, what? _____

Are you taking any over the counter medications, herbs , supplements, etc.? ☐ Yes ☐ No

If yes, what? _____

Are you taking any medications for allergies? ☐ Yes ☐ No

If yes, what? _____

Do you have any physical, emotional, or mental condition now or in the past that I need to be aware of? ☐ Yes ☐ No

If yes, what? _____

Have you ever been hospitalized? ☐ Yes ☐ No

If so, for what? _____

CURRENT REASON FOR SEEKING COUNSELING:

Briefly describe the problem for which you wish to have counseling?

_____

_____

_____

What would you like to see happen as a result of counseling?

_____

_____

_____

_____

The thing which concerns me the most right now is?

_____

_____

_____