BASIC INFORMATION FORM **TODAY'S DATE:** _____

Client's Name: _____ Sex: _____
first middle last

Date of Birth: _____ Age: _____ Social Security Number: _____

Address:_____

_____

E-mail Address: (OPTIONAL) E-mail is not a secure medium and I cannot be responsible for the confidentiality of your message – Brief messages ONLY – for ex., scheduling changes - DO NOT USE FOR ANY EMERGENCY CONTACT.

E-mail Address: _____ Home Phone #:_____

Cell Phone #:_____ Work Telephone #:_____

Circle the Telephone Numbers I should use when I need to contact you.

Emergency Contact Name: _____ Phone #: _____

Workplace or School: _____

Marital Status (CIRCLE): Married Cohabiting Widowed Divorced Separated Single Other_____

People in Your Household

Name	Age	Relationship to You
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Primary Care Physician Name: _____

Address: _____

(NECESSARY) Telephone #: _____ Fax #: _____

Approximate date of most recent medical examination: _____

Chronic physical health conditions or limitations requiring special accommodations that may effect your treatment (i.e., Reading, Hearing, Mobility, Vision, or Speech Impairment)? : **Y N** (If yes, please list):

_____

How were you referred to my practice? _____

List reasons you selected me to work with: _____

Have you ever I been in counseling before? When? _____

What was your experience like?_____