Client Information

Name: ___________________________ Date of Birth: ____/____/____

Address: ____
Street *City* *State* *Zip*

Phone: __________________ Email: _________________________________

Emergency Contact: ________________________ Relationship to you: ________________

Phone number for emergency contact: ________________________

Current gender (optional): __________________ Pronouns (optional): ________________

Relationship Status:

___ single ___ married ___divorced ___widowed ___ partnered/in a committed relationship

Employer/School: __________________________ Occupation:________________________

Medical Conditions:

Prescription Medications:

Previous Psychotherapy Experiences:

Individual counseling:	No	Yes	Dates: ___________________________
Couples or Family therapy:	No	Yes	Dates: ___________________________
Inpatient hospitalization:	No	Yes	Dates: ___________________________
Psychiatric medications:	No	Yes	Date and types: _____________________

Reason for seeking therapy today: