



Office Use Only	Diagnosis Code	
*County of Residence		
*Ethnicity		

CLIENT INFORMATION	COMPLETE FRONT AND BACK
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DATE: _____

NAME _____ DOB _____

ADDRESS _____ SSN _____

HOME PHONE _____ MARITAL STATUS: S M D W

WORK PHONE _____ BEST TIME TO REACH YOU _____

LENGTH OF CURRENT EMPLOYMENT _____

EMPLOYER _____

WORK ADDRESS _____

EDUCATION _____

PARTNER OR PARENT'S NAME _____

ADDRESS _____ DOB _____

_____ SSN _____

HOME PHONE _____ WORK PHONE _____

EMPLOYED BY _____

LENGTH OF EMPLOYMENT _____

EDUCATION _____

CHLDREN	SCHOOL	AGE
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RELIGIOUS AFFILIATION _____

DOCTOR'S NAME AND PHONE NO. _____

NEAREST RELATIVE OR CLOSE FRIEND _____

PHONE _____

REFERRED BY _____

* This information is requested by our grant-making agencies.

YEARLY INCOME

YOURS _____
PARTNER'S _____
CHILD SUPPORT _____
INVESTMENT _____
PARENTAL ASSISTANCE _____

METHOD OF PAYMENT

CHECK

CASH

INSURANCE

REASONS FOR SEEKING COUNSELING AT THIS TIME

ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO SHARE

HAVE YOU HAD PRIOR PSYCHOTHERAPY? YES or NO. If Yes, when and with whom?
