CLIENT INFORMATION
CONFIDENTIAL

PERSONAL & FAMILY

Name (First/Last):_____ DOB: _____ Age: _____ Sex:_____

☐ Minor ☐ Single ☐ Married ☐ Cohabitate ☐ Separated ☐ Divorced ☐ Widowed

Address: _____ Okay to send mail? ☐

City:_____ State: _____ Zip:_____ Okay to phone/text? ☐

Phone: (_____)_____Cell Phone: (____)_____Work Phone: (____)_____ Okay to leave message? ☐

Email: _____ Okay to email? ☐

Employer:_____ Position: _____

Spouse's Name: _____ Employed by: _____

Names & Ages of Children: _____

_____

Religious affiliation (if any): _____

_____

EMERGENCY CONTACT

Name (First/Last):_____ Relationship:_____

Address:_____

City:_____ State: _____ Zip: _____

Phone: (_____)_____Cell Phone: (_____)_____Work Phone: (_____)_____

MEDICAL

Current Physician(s): Name, Address & Phone: _____

_____

Current health concerns: _____

_____

_____

Present medications & dosage: _____

_____

Reason for seeking therapy: _____

_____

_____

_____

_____

Referred by: _____

CHERYL COOPER Counseling

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