Client Information Form

Please print clearly in blue or black ink.

Date: _____

Personal Information

Full Legal Name

Date of Birth (MM/DD/YYYY)

Mobile Phone

Street Address

City | State | ZIP Code

Email Address

Preferred Contact Method

- ○ Phone
- ○ Email
- ○ Text Message

Best Times to Reach You

Emergency Contact

Name

Relationship

Phone Number

Household & Family

Relationship Status (choose one)

- Single
- Dating
- Married
- Divorced
- Separated
- Other

How long?

Who currently lives in your household? Please list names, ages, and relationship.

Do you have children with your ex-partner?

Medical & Medication History

Primary Care Physician & Contact

Current Medications & Dosages

Relevant medical conditions, surgeries, or allergies

Therapy Background

Have you previously attended therapy?

Email (optional)

If yes, when

Did it help?

Concerns

Briefly describe the concerns that led you to seek services at this time.

I certify that the information provided is current and accurate to the best of my knowledge.

CLIENT SIGNATURE

DATE