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CLIENT DATA

*(Please complete this form before your first appointment. All information will be held **confidential** in accordance with State and Federal Law. Please print legibly in **ink**. Use additional paper if necessary.)*

First Name _____ Last Name _____

Today's Date: _____ Client ID: _____

Date of Birth:_____ Age: _____ Ethnicity: _____ Male / Female

Single / Engaged / Married / Divorced / Widowed / Co-habitant Relationship

Type of Counseling: Individual ___ Pre-marital ___ Marital ___ Family ___ Relationship ____

Home address: _____
Street address

_____
City State Zip

Mailing address: _____

_____
City State Zip

Secure Email: _____

MAY WE CONTACT YOU VIA EMAIL: ___YES ____NO

#1 Contact number (_____)_____ #2 Contact number (_____)_____

May we contact you at both phone numbers? _____ What are the best times to reach you?

_____

Who referred you to counseling? Self: ____ Friend: ____ Other:_____

Name and Address of referral source:_____

Emergency Contact Person: _____ Phone: _____