Client Information

Name _____ **Email** _____

Address _____

Cell Phone _____ **Is it ok to receive texts Y N**

Age _____ **Referred by** _____

Work Information

Occupation _____ **Your responsibilities** _____

_____

Additional Information

How would you describe yourself? _____

_____

Have you ever had counseling? Y N If so, what tools have been helpful? _____

_____

Do you have any physical illnesses or injury. If so, please describe ? _____

_____

Are you presently taking any medication (name of prescription and for what)? _____

_____

Are you under the care of a Psychiatrist? Y N Name of Psychiatrist? _____

How would you like your life to be different in each of the following areas?

Work _____

Relationship _____

_____

Family/Friends _____

Health _____

Spiritual _____

What are some of your core values? _____

_____

(Continue on Next Page)

What are some of your strengths? _____

_____

Are there any undesirable habits that affect you or your relationships? (For example: alcohol, drugs, smoking, pornography, sex, overspending, gaming, obsessing, eating) If so, please explain _____

_____

Children

Name	Age	Male/Female
1.		
2.		
3.		
4.		
5.		
6.		

Jun-19_____

_____

If you are here for your relationship, please answer the following questions.

How would you describe your relationship?_____

_____

_____

On the scale below, mark your level of commitment to the relationship

1 2 3 4 5

Low High

On the scale below, mark your level of commitment to counseling

1 2 3 4 5

Low High

Anything else you would like me to know?_____

_____