Name: **Date of Birth:**	
Address:	
Home Phone:	
Cell Phone:	
E-mail (optional)	

1. **Why are you seeking counseling at this time?**
   _____
   _____
   _____
   _____
   _____
   _____
   _____
2. **Was there an event or situation that recently happened that convinced you to come to counseling? Yes___ NO__ (If yes please explain)**
   _____
   _____
   _____
   _____
   _____
   _____
   _____
3. **Have you ever seen a therapist in the past? Yes___ No____ (If yes please put down their name and contact information if you have it).**
   _____
   _____
   _____
   _____
4. **What is your level of education?**
   _____
   _____

5. **Are you currently working outside of the household? Yes____ No_____ (If yes please tell me you job title and place of current employment.**

   _____
   _____

6. **Do you have any physical difficulties that cause problems now? Yes____ NO____ (If Yes please explain)**

   _____
   _____
   _____
   _____

7. **Please list any medications you are now on including over the counter medications.**

Medication	Dose	How often do you take it	Side effects

8. **Did you have any major childhood illnesses? Yes____ NO ____ (If yes please explain)**

   _____
   _____
   _____
   _____

9. **Do you have any current legal problems? Yes___ No ____ (If yes please explain)**

   _____
   _____
   _____
   _____
   _____

10. **Do you drink alcohol? Yes ____ No ___ (If yes, how much and how often)**

_____
_____
_____
_____

11. **Do you use any mood altering substances that are not prescribed by a Doctor? (If Yes please list what you use, how much, and how often)**

_____
_____
_____
_____
_____
_____

12. **Do you practice any organized religion or have any spiritual practices? Yes___ NO ___ (If yes please explain)**

_____
_____

13. **Is there anything else that you feel would be helpful for me to know? No____ Yes_____**

_____
_____
_____
_____
_____

_____

Client Signature

_____

Date

_____

Therapist Signature

_____

Date