GENERAL INFORMATION

Name________________________Birthdate_____/______/______Soc.Sec#_____/___/_____

Address ____

City____ZipCode___________________

Home Phone _______________________ Business or Cell Phone_______________________

Permission to leave message: __YES ___NO   Referred by____________________________

School (if minor) __________________________Counselor____________________________

Employer Name____

Position ______________________ No. Of years ____ Annual Household income __________

Members of Household (names)	Relationship to You	Age
_________________________	_________________________	_______________
_________________________	_________________________	_______________
_________________________	_________________________	_______________
_________________________	_________________________	_______________

Please describe any legal action you may have taken or which may have been taken against you for any reason at any time ____

Briefly describe any health problems or physical symptoms you may have _______________

____

Reason(s) for seeking services at this time ____

____

Previous Counseling Experiences: Date ________to ________With whom? _______________

Reason for seeking services then: ____

Please List Medications you are taking, who prescribed them and why:

____

Please List Drugs and Alcohol you use: ____

Frequency? ____

Have you ever Seriously Considered or Attempted Suicide? ____________________________

Client Signature _______________________Parent/Guardian Signature___________________

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