Client Information Sheet

Name: _____ Age: _____ Date of birth: _____

Preferred phone number: _____ (circle one:) home/cell

Address: _____ City:_____ State: _____ Zip: _____

Email address: _____

Place of Employment: _____ Job held: _____

Marital Status (circle): Single Married Widowed Divorced Separated

Spouse's name: _____

How did you about me? _____

Do you attend church? Yes/No Where? _____

Have you had any previous counseling? Yes/No
If so, when and where? _____
Was it helpful? Yes/No Why or why not? _____

Please briefly describe what has caused you to seek counseling at this time:

_____

_____

Please describe what you hope to come from counseling. In other words, if counseling "works," how will you know?

_____

_____

_____

In your own words, please tell me about your relationship with God. In other words, who is God to you and how is God a source of support for you?

_____

_____

Please put a check beside any of the items below that describe problems you are now facing:

___Depression
___Anxiety
___Marriage problems
___Work pressures
___Physical problems/illness
___Spiritual Crisis
___Thoughts of Suicide
___Past abuse—physical, sexual, or emotional
___Current abuse--- physical, sexual, or emotional
___Substance abuse
___Anger
___Problems with children
___Pornography/ Sexual addiction
___Eating Disorder
___Guilt

Are you on any psychiatric medications? Yes/No If so, please list:

_____

Is there anything else you would like for me to know before we begin?

_____

_____

In case of emergency please notify: _____

Relationship: _____ Phone (h) _____ (c) _____