Client Information Form

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Name: _____ Dob: _____
Address:_____
Cell Phone: _____
OK to text? yes _____ no ____
OK to use email for communication: yes ___ no ____if yes, write email _____
Emergency contact: _____ cell phone: _____

Marital status: single __ domestic partners __ married ___ Divorced __ Separated __ Widowed __

Company;_____ Job Title: _____

Have you been in counseling before? yes _____ no_____

Do you have significant medical problems? yes _____ no_____

Are you currently taking any medication for mental health treatment?
yes ____ no____ List: _____
How often do you use alcohol? Never __ Once/ month __ 2+ week __ daily __
How often do you use cannibis? Never ___ Once/month __ 2+ week ___ daily __

Is there anything else I should know about you?
_____

_____