ELISABETH A. EDWARDS, MA, LMHC, LMFT

CLIENT INFORMATION FORM

NAME: ______________________ DATE: ______________

AGE: __________ DATE OF BIRTH: ______________ SEX: M F

GENDER: M F NON BINARY PRONOUNS: ______________

MARITAL STATUS: ____ SINGLE ____ MARRIED ____ SEPARATED ____ DIVORCED ____ PARTNERSHIP

LIVING SITUATION: ____ LIVES ALONE ____ LIVES WITH ROOMMATE ____ LIVES WITH SIGNIFICANT OTHER
____ LIVES WITH FAMILY ____OTHER: ______________

ADDRESS: ______________________

CITY: ______________ STATE: ________ ZIP CODE: ________

MAIN PHONE: ______________ OK TO LEAVE MESSAGE: YES NO

OTHER PHONE: ______________ OK TO LEAVE MESSAGE: YES NO

EMAIL ADDRESS: ______________________

REFERRED BY: ______________________

SCHOOL ATTENDING: ______________ GRADE/MAJOR: ________

OCCUPATION: ______________ EMPLOYER: ______________

EMERGENCY CONTACT: ______________________

PHONE NUMBERS: ______________________

ADDRESS: ______________________

CITY: ______________ STATE: ________ ZIPCODE: ________

RELATIONSHIP TO YOU: ______________________

PARTNER: ______________ YEARS TOGETHER: ________

PHONE: ______________ DOES YOUR PARTNER KNOW YOU ARE IN COUNSELING? Y N

PARTNERS'S OCCUPATION: ______________________

PARTNER'S EMPLOYER: ______________ TIME EMPLOYED: ________

DO YOU HAVE CHILDREN? YES NO DO YOU WANT TO HAVE CHILDREN? YES NO UNSURE

NAMES AND AGES OF CHILDREN: ______________________________

____

NUMBER OF MISCARRIAGES: __________ DATES: ______________________________

NUMBER OF ABORTIONS: __________ DATES: ______________________________

HAVE YOU RECEIVED COUNSELING FOR EITHER OF THESE? YES NO

LIST ALL IMPORTANT PEOPLE IN YOUR LIFE:

NAME: ______________________ AGE: ________ STILL LIVING? YES NO

DESCRIBE HIM / HER: ______________________________

NAME: ______________________ AGE: ________ STILL LIVING? YES NO

DESCRIBE HIM / HER: ______________________________

NAME: ______________________ AGE: ________ STILL LIVING? YES NO

DESCRIBE HIM / HER: ______________________________

NAME: ______________________ AGE: ________ STILL LIVING? YES NO

DESCRIBE HIM / HER: ______________________________

NAME: ______________________ AGE: ________ STILL LIVING? YES NO

DESCRIBE HIM / HER: ______________________________

PLEASE LIST ANY PHYSICAL AILMENTS AND MEDICATIONS:

____

____

____

PLEASE DESCRIBE YOUR SPIRITUAL LIFE INCLUDING ANY PLACE OF WORSHIP OR RETREAT:

____

____

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WHAT BROUGHT YOU INTO COUNSELING?

____

____

WHAT ARE YOUR GOALS FOR COUNSELING?

____

____

HAVE YOU EVER BEEN IN COUNSELING BEFORE? YES NO

WAS IT HELPFUL? YES NO PLEASE EXPLAIN: ____________________________________

CIRCLE ALL THAT APPLY:

Dizziness	Sleep Trouble	Tension	Intestinal Trouble	Harming Self
Tiredness	Seeing Things	Stomach Trouble	Trouble with Job	Body Image
Rapid Heart Rate	Hearing Noises	Pain	Headaches	Harming Others
Visual Trouble	Difficulty Breathing	Change in Appetite	Hearing Voices	Trouble Relaxing
Stress	Panic	Guilt	Recent Death	Family Issues
Inferiority Feelings	Shyness	Temper	Marriage Problems	Fears
Emotional Abuse	Bad Dreams	Unwanted Thoughts	Impulsive Behavior	Unhappiness
Sexual Problems	Legal Matters	Making Decisions	Shame	Hormones
Recent Loss	Nervousness	Eating Problems	Apathy	Blackouts
Grief	Defective Feelings	Finances	Miscarriage	Abortion
Communication	Verbal Abuse	Anger	Concentration	School Problems
Memory	Self-Control	Pregnancy	Trauma	Spiritual Pain
Substance Use	Ambition	Pornography	Hopelessness	Chronic Pain
Anxiety	Depression	Terminal Illness	Physical Abuse	Rage
Loneliness	Parenting Stress	Friend Issues	Career Distress	Compulsivity
Sexual Abuse	Aggressiveness	Racing Thoughts	Loss of Control	Safety
Chronic Fatigue	Gender Identity	Other: ____________________		