

Peggy Hinders, MA, LPC
Licensed Professional Counselor

Client Information Form

Today's Date _____

Client Name _____ Birthdate _____ Age _____

Address _____ Home Phone (____) _____

_____ Cell Phone (____) _____

City State Zip Code

OK to call and leave a message? _____ Email _____

Education (Grade Completed) _____ Employer _____

How did you hear about my practice? _____

Marital Status:

Single Married Divorced Remarried Separated Widowed Cohabiting

How long (if applicable): _____

Spouse Information, if applicable:

Spouses Name _____ Age _____

Education (Grade Completed) _____ Employer _____

Do you have children or step-children? _____

Child Names **Age**

Emergency Contact

Name / Relationship

Address

Phone

List the names of those who make up your emotional/social support system. (Family, friends)

Are your parents: Married Divorced Deceased How long? _____

Hobbies _____

Describe your exercise program _____

List the medications you are currently taking (Dosage/Frequency) _____

Do you take prescription Birth Control or HRT? _____ If so, what? _____

Prescribing physician _____ Phone _____

List any side effects of these medications that you have observed _____

How much/often do you drink? _____

Do you or anyone in your family have a drug or alcohol problem? (Now or in the past) _____

Please describe your reasons for seeking counseling _____

Please list current or previous efforts to resolve the items described above _____

How will you know if counseling is helping? _____

What do you see as your strengths and skills? _____

Do you consider yourself a spiritual person? (Explain) _____

Is there any other information that I need to know in order to help you achieve your counseling goals?
