

Client Information Form

*** Please note that all information will be treated as private and confidential ***

1. Date: _____

2. Name: _____ DOB: _____ Gender: M or F

3. Address: _____

4. Email: _____

5. Phone: (home) _____

(cell) _____

(work) _____

6. Height: _____ Weight: _____

7. Reason for visit: _____

8. How long has this problem persisted? _____

9. Were you referred for counseling? If yes, by whom? _____

10. If you weren't referred, how did you find Teton Counseling? _____

11. Have you previously received counseling services? Y or N

12. If yes, for what issue(s) and for how long? _____

13. Name of your primary care physician: _____

14. Please list any health issues (past or present) that affect your daily living:

15. Are you currently taking any medication? If yes, please list reason:

16. What do you hope to accomplish in our counseling work together? _____
