Informational Sheet

Type of Counseling: __Individual __Marital/Couples

Name_____ Date_____

Address: _____
City_____ State_____ Zip_____
Home number_____ Cell_____

Date of Birth_____ Age_____ Gender_____

Marital Status: __Married __Single __Separated __Divorced

Employment_____

Emergency Contact: _____ Phone_____

If Child: School_____ Grade_____

Brief description of problem _____
_____
_____
_____

Are you currently seeing a psychiatrist? __Yes __No

How long have this problem existed? _____

What ways have you attempted to cope? _____
_____

Will you have a problem with payment? __Yes __No

Who referred you to me? _____