Counseling Specialists, LLP
Adult Client Information Form

Client _____ (M) ____ (F) ____ Birth Date _____ Age _____
Last Name First Name Middle Initial
Address _____Phone ( ) _____
Street City/State Zip Leave Mess._____Yes_____No
Referral Source _____ Cell ( )_____
Leave Mess_____Yes_____No
E-Mail Address_____

Employer_____Phone ( )_____
Name Address Leave Mess._____Yes_____No

Employment Status: Full/Part time (circle one please) Occupation_____

Marital Status: Married _____ Single _____ Partnered_____ Divorced _____ Separated _____Widowed_____
Date Married_____ Divorced Date _____

Religion _____Highest Grade Completed_____

Primary Physician_____ Psychiatrist _____

Problem for which you are seeking services, _____

Current Medications: _____

Emergency Contact, _____ Phone ( ) _____

Spouse/Significant Other Information

Spouse/S.O. _____(M)___(F)___Birth Date _____ Age _____
Last Name First Name Middle Initial
Address (if different from client) _____Phone ( ) _____
Street City/State Zip Leave Mess. _____Yes _____No

Cell Phone ( ) _____ Leave Mess. ____Yes _____No

Employer, _____ Phone ( ) _____ Leave Mess. _____Yes _____ No

Occupation _____Highest Grade Completed _____

Other Family Members: **(children, stepchildren, and/or other people residing in your home)**

Name	DOB	Age	Home/Away