**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 |
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