



APPLICATION FOR SERVICE

Please complete the following information to better help your counselor assess your situation. The information will be kept confidential. If you are completing this as a parent or guardian of a prospective client, please give information pertaining to that person.

CLIENT INFORMATION

Today's Date: _____

Last Name: _____ First Name: _____ Date of Birth: _____ Current age: _____

Address _____ Apt. _____

City: _____ State: _____ Zip: _____

Highest grade/Degree completed: _____

Current Employer: _____

Home Phone: _____

Business Phone: _____

Home E-Mail: _____

Business E-Mail: _____

In case on an emergency please contact...

If not employed, most recent employer: _____

Name: _____

For Clients under the age of 16:

Home Phone: _____

Name of Parent/Guardian/Guarantor: _____

Work Phone: _____

MARITAL INFORMATION

Currently I am:

If applicable, please give information about marriages:

Single

Current Spouse:

Previous Spouse:

Engaged

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Married

Year Married: _____

Year Married: _____

Separated

Year Separated: _____

Year Separated: _____

Divorced

Year Divorced: _____

Year Divorced: _____

Widowed

Year Widowed: _____

Year Widowed: _____

FAMILY INFORMATION

Is your mother living? Yes No

Is your father living? Yes No

Were you raised by anyone other than your biological parents? Yes No If Yes, by whom? _____

If applicable, please give information about your children:

1st child – Name: _____ Age: _____

2nd child – Name: _____ Age: _____

Adopted: Yes No Living: Yes No

Adopted: Yes No Living: Yes No

3rd child – Name: _____ Age: _____

4th child – Name: _____ Age: _____

Adopted: Yes No Living: Yes No

Adopted: Yes No Living: Yes No

MEDICAL INFORMATION

How would you describe your overall health? _____

Has there been any change in your weight in the past year? Yes No If yes, please explain: _____

Has there been any change in your sleep patterns in the past year? Yes No If yes, please explain: _____

Physician's Name: _____ Date and Report of last physical: _____

List any current medications, MG's, and for what purpose taken:

PREVIOUS COUNSELING INFORMATION

Have you had counseling in the past? Yes No

If yes, when? _____ Name of counselor/therapist: _____

For what purpose?

Ever diagnosed?

Would you be willing to sign a **Release of Information** form giving permission to obtain records from your previous counselor?

Yes No

CURRENT NEED DESCRIPTION

Describe briefly the major concern that brings you for counseling at this moment:

Describe what you have done about this concern prior to this appointment:

Have you had any thoughts of hurting yourself or someone else? _____ If yes, please describe (how long ago, yourself or others, did you have a plan?)

- *I understand that because the counselor has reserved time exclusively for me, it is absolutely necessary that I notify my counselor at least 48 hours in advance if it is necessary to cancel my appointment. I understand that I will be charged my regular fee for "no show" or late cancellations with the exception of illness or emergencies. Initial _____*
 - *I have read the **STATEMENT OF DISCLOSURE** and have had an opportunity to ask any questions. Initial _____*
 - *This is to certify that I have read and understand the terms stated above and hereby consent to counseling in full accordance with these terms. Initial _____*
- (If under 16, must be signed by parent or legal guardian)*

Signature: _____ Date: _____

Signature: _____ Date: _____