

Client Information Form

Date:	
Client's Name	Male or F (circle)
Date of Birth:	
Has the client or far	mily received counseling in the past: Yes or No Outcome:
Client's Parent or G	duardian:
Name:	Relationship to Client:
Address:	City: State: Zip:
School Informatio	n:
School:	Previous Schools
Grade Level:	Performance: Math ELA (Reading and Writing)
Previous Retentions	s: Yes or No If yes, what grade:
Learning Difficultie	es: Yes or No If yes explain:
Speech/Language I	Difficulties: Yes or No If yes explain:
Glasses: Yes or N	To IEP: Yes or No 504 Plan: Yes or No
Attitude about scho	ool:
_	m : Be as specific as you can: When did it start, how does it affect the client
Severity of the prob	olem: Mild Moderate Severe Very Severe
Contact Informati	on:
Home:	May I contact you at home and leave messages? Yes or No (circle)

Cell:May I leave voice or text messages on your cell? Yes or No (circle) Email:May I contact you by email and leave messages? Yes or No (circle) Status of Biological Parents: Married Divorced Separated Cohabitant Single Other Mother's Name: Occupation: Father's Name: Occupation: Guardian(s) Name: Occupation(s): Stepparent(s): Siblings Name: Age: Biological Half Step Siblings Name: Age: Biological Half Step Siblings Name: Age:	Work:	May I contact you at work and leave messages? Yes or No (circle)							
Status of Biological Parents: Married Divorced Separated Cohabitant Single Other Mother's Name: Occupation: Father's Name: Occupation: Guardian(s) Name: Occupation(s): Stepparent(s): Siblings Name: Age: Biological Half Step Client Medical Information: Last visit List any medical conditions and diagnoses: Hours of sleep per night: Diet: Medications: Relevant Family Medical Information: (please list any disorders or medical conditions) Mother: Father: Siblings: Siblings: Siblings: Siblings: Siblings: Siblings: Siblings: Siblings: Siblings: Diet: Siblings: Siblings:	Cell:	May I lea	May I leave voice or text messages on your cell? Yes or No (circle)						
MarriedDivorcedSeparatedCohabitantSingleOther Mother's Name:Occupation: Father's Name:Occupation(s): Guardian(s) Name:Occupation(s): Stepparent(s): Siblings Name:Age:BiologicalHalfStep Siblings Name:Age:BiologicalHalfStep Siblings Name:Age:									
Mother's Name:Occupation:	Status of Biologi	cal Parents:							
Father's Name:Occupation:	MarriedDivo	orcedSeparated_	Cohabitant	Single	_ Other	_			
Guardian(s) Name:Occupation(s):	Mother's Name: _		Occı	ıpation:					
Stepparent(s): Siblings Name: Age: Biological Half Step Step Client Medical Information: Primary Care Physician: Last visit List any medical conditions and diagnoses: Hours of sleep per night: Medications: Relevant Family Medical Information: (please list any disorders or medical conditions) Mother: Father: Siblings:	Father's Name: _		Occu	Occupation:					
Siblings Name: Age:Biological Half Step Siblings Name: Age: Biological Half Step Step	Guardian(s) Nam	e:	Occu	pation(s):					
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Medications: Relevant Family Medical Information: (please list any disorders or medical conditions) Mother: Father: Siblings:									
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Mother: Father: Siblings:	Medications:								
Mother: Father: Siblings:		No Politica de	(1 1 1)	1' 1	1' 1 1'				
Father:Siblings:	_		_		edical condi	itions)			
Siblings:									
	Siblings:								
How did you learn about this practice?	How did you lear	n about this practice?)						