Skills Based Counseling PLLC
SBC

Client Information Form

Date:

Client's Name Male or F (circle)

Date of Birth:

Has the client or family received counseling in the past: Yes or No Outcome:

_____

Client's Parent or Guardian:

Name: _____ Relationship to Client:_____

Address: _____ City: _____ State: _____ Zip: _____

School Information:

School**:** _____ Previous Schools _____

Grade Level: _____ Performance: **Math** _____ **ELA** (Reading and Writing) _____

Previous Retentions: Yes or No If yes, what grade: _____

Learning Difficulties: Yes or No If yes explain:_____

_____

Speech/Language Difficulties: Yes or No If yes explain: _____

_____

Glasses: Yes or No **IEP**: Yes or No **504 Plan**: Yes or No

Attitude about school: _____

Homework habits: _____

Presenting Problem: Be as specific as you can: When did it start, how does it affect the client and/or family?

_____

_____

_____

Severity of the problem: Mild _____ Moderate _____ Severe _____ Very Severe _____

Contact Information:

Home: _____May I contact you at home and leave messages? Yes or No (circle)

Work: _____ May I contact you at work 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 ___

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Client Medical Information:

Primary Care Physician: _____ 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: _____

How did you learn about this practice? _____