

# Grace Counseling

(Please print clearly)

## CLIENT INFORMATION (FOR ALL CLIENTS)

Client Name (First, Middle Initial, Last)		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth date
Street address		City, State, and Zip Code		
Home Phone	Work Phone		Cell Phone	
Occupation	Employer or School		Primary Care Physician	
Who referred you to this practice?		Have you seen our website? <input type="checkbox"/> Yes <input type="checkbox"/> No	General Health Status	
Any previous counseling? With whom?				
List all medications				

Emergency Contact		Relationship to client		
Home phone	Cell Phone		Work Phone	
Responsible for Payment	Home Phone		Cell Phone	
Street address		City, State, and Zip Code		

## IF MARRIED

Spouse's Name (First, Middle Initial, Last)		Birth date	Cell Phone
Occupation	Employer or School		Work Phone

## IF A MINOR

Mother's Name		Occupation	Employer
Street Address		City, State, and Zip Code	
Home Phone	Cell Phone		Work Phone
Father's Name		Occupation	Employer
Street Address		City, State, and Zip Code	
Home Phone	Cell Phone		Work Phone
Siblings (first & last names and ages)			

The above information is true to the best of my knowledge.

**CLIENT SIGNATURE (or Parent/Guardian if under age 18)**

**DATE**