Andrea P. Tulley, LLC

LPC, M.A, NCC
Licensed Professional Counselor

CLIENT INFORMATION FORM

Contact Information

Date _____

Client Name _____

Address_____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Work** _____ **Cell** _____

Birth Date _____ **SS#** _____

Sex _____ **Age** _____ **Marital Status** _____

Occupation _____

Employer/School _____

Spouse's Name _____ **Spouse's SS#** _____

If client is a minor, parents' name(s) and address(es)

_____

_____

Who referred you? _____

Emergency Contact Name _____ **Phone #**_____

Relationship _____

Medical History

Client's physician, psychiatrist or therapist (list names, titles and phone #'s)

_____

_____

Indicate any relevant medical history, including hospitalizations

_____

_____

Insurance Information

Primary insurance company (name, address and phone #)

_____

_____

Name and birth date of person insured _____

ID# _____ **Employer or group number** _____

Please list all who currently live in client's home

Name	Sex	Age	Relationship	Occupation

_____

_____

_____

Reason for seeking counseling _____

Do you smoke? If so how much? _____

Do you consume alcohol? If so, how much and how often? _____

How much caffeine, if any, do you have per day? _____

Symptom Checklist (please circle any of the following issues that pertain to the client)

Nervousness	Depression	Fears	Behavioral Problems
Shyness	Sexual Problems	Career	Suicidal Thoughts
Separation	Change in Relationship	Finances	Parenting
Drug Use	Alcohol Use	Friends	Children
Loneliness	Anger	Self-Control	Legal Issues
Unhappiness	Appetite	Concentration	Work
Sleep	Stress	Medical	Headaches
Tiredness	Temper	Impulsivity	Marriage
Legal Matters	Memory	Ambition	Nightmares
Energy	Insomnia	Decision-Making	

Please elaborate on any of above circled

_____

_____

_____

_____