Carol Grace, MA, LMFT
Counseling and Psychotherapy Services

CLIENT INFORMATION

Name: ____ ***Date:*** ___________

Address: ____________________________ ***Zip:*** ______ ***email:*** ________________

Phones: Home _______________ ***Cell:*** ________________ ***Work:*** _______________

Age: _____ ***Birthdate:*** _______________ ***Birthplace:*** ___________________

Occupation: ________________ ***Location:*** ________________ ***How Long?*** ______

Highest Educational level/training completed: _____________ ***Where?*** ___________

Children and Ages: ____

Key People in Your Life: ____

Relationship Status: ***single married living with divorced separated widowed***

Living Situation: ***alone spouse/partner children roommate(s) parent(s)***

Religion: Raised in? _____________ ***Currently Spirituality:*** __________________

Primary Physician: _________________ ***Other Health Practitioners:*** ____________

List Any Significant Health Problems: _____________________________________

List any current Medications and dosage: __________________________________

Have you been in therapy before? _____ ***With Whom?*** __________________________

What concerns were addressed? ____
Were your parents separated or divorced? _____ ***When?*** ________________________

Did you experience verbal, physical, or sexual abuse as a child? ________________

Annual Income: ***SS# (for insurance):***

What concerns bring you in now? ____

Referred by: ____