THRIVE INTERVENTION COUNSELING

Client Information Form

DATE: ___ /___ /___

Name: _____

Soc Sec #:_____Birth date: _____ Age: _____

Address: _____

Best phone # to reach me: _____ (W / H / C) OK to leave Msg? _____

2nd Best phone #:_____(W / H / C) OK to leave Msg? _____

E-Mail Address: _____OK to E-mail? _____

Relationship Status: Married___ Single___ Divorced___ Separated__ Partnered__ Boy/Girlfriend__ Widowed __

Name of Spouse/Partner/Boy /Girlfriend: _____ Age:_____

CHILDREN (please include step kids):

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

PARENTS:

Mother's name_____ Living ____ Deceased____

Father's name _____ Living ____ Deceased____

SIBLINGS (Names & ages of siblings (please include half or step siblings):

Name: _____ Age: __ Name: _____ Age: __

Name: _____ Age: __ Name: _____ Age: __

FAMILY BACKGROUND

Place of Employment: _____ full/part-time

Highest grade, certifications or degree achieved in school? _____

Religious/ Spiritual Affiliation: _____

Hobbies, Civic, Social Activities: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: _____

Allergies: _____ Medical Conditions: _____

Current Medications: _____

PURPOSE OF VISIT? Why are you seeking counseling at this time?