Grace Counseling

(Please Print)

CLIENT INFORMATION (FOR ALL CLIENTS)

Client Name (First, Middle Initial, Last)	**Marital status** ❑ Single ❑ Married	**Sex** ❑ M ❑ 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? ❑ Yes ❑ 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 if differs from client info	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 (If under 18 yrs. old, Parent/Guardian) _____ **DATE** _____