

# Client Personal Data



Today's Date: \_\_\_\_\_

**Name** \_\_\_\_\_

Is client a minor? (Under age 17) Yes \_\_\_ No \_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Work \_\_\_\_\_

Mobile # \_\_\_\_\_ E-mail: \_\_\_\_\_

Place of employment \_\_\_\_\_

Occupation \_\_\_\_\_

Age \_\_\_\_\_ Birth date: \_\_\_ \_\_\_ \_\_\_

**Spouse Name** \_\_\_\_\_

Work # \_\_\_\_\_

Mobile # \_\_\_\_\_ E-mail: \_\_\_\_\_

Place of employment \_\_\_\_\_

Occupation \_\_\_\_\_

Age \_\_\_\_\_ Birth date: \_\_\_ \_\_\_ \_\_\_

## If Minor:

Birth Father's Name: \_\_\_\_\_

Step Father's Name \_\_\_\_\_

Birth Mother's Name: \_\_\_\_\_

Step Mother's Name \_\_\_\_\_

Responsible Party \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ St. \_\_\_ Zip \_\_\_\_\_

Who is the legal guardian for minor client? \_\_\_\_\_

**Couples:**

How long have you been married? \_\_\_\_\_ Living together? Yes \_\_\_\_ No \_\_\_\_

Are you presently separated? If so, how long? \_\_\_\_\_

Have you been divorced before? How long ago \_\_\_\_\_ How many times \_\_\_\_

How long were you married? \_\_\_\_\_

Do you have children from the marriage or marriages? How many? \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Name \_\_\_\_\_ Age \_\_\_\_\_

Do they live with you? Yes \_\_\_\_ No \_\_\_\_

Do you get visitation? Yes \_\_\_\_ No \_\_\_\_ How often? \_\_\_\_\_

**Please list all Members of Your Household**

Name	Relationship / Age	Sex
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1.		
2.		
3.		
4.		
5.		
6.		

**Emergency Contact Information**

Who could we contact in case of an emergency?

Name / Phone \_\_\_\_\_

**Health:**

What is your health? Good\_\_\_ Fair\_\_\_ Poor\_\_\_

Last Physical \_\_\_\_\_

What medications are you taking?  
\_\_\_\_\_

Have you now or in the last 5 years suffered from?

Nervous breakdown\_\_\_

Panic attacks\_\_\_

Depression \_\_\_

Suicide attempt \_\_\_

Have you been or are you now in an abusive situation? Yes\_\_\_ No\_\_\_

Have you experienced sexual abuse? Yes\_\_\_ No\_\_\_

Do you have an STD? Yes\_\_\_\_\_ No\_\_\_\_\_

**If applies:**

Are you pregnant? Yes\_\_\_ No\_\_\_

How many, if any, miscarriages have you experienced? \_\_\_\_\_

Have you had an abortion? Yes\_\_\_ No\_\_\_

If yes: how many\_\_\_\_\_ what age were you? \_\_\_\_\_

Have you given up a child to adoption? Yes\_\_\_ No\_\_\_

If yes: how many? \_\_\_\_\_ When? \_\_\_\_\_

Do you have contact? Yes\_\_\_ No\_\_\_\_\_

**Childhood Information**

What birth order are you in your family? Oldest Middle Youngest

How many siblings do you have? \_\_\_\_\_

**Parent Information**

Are your parents divorced? Yes \_\_\_ No \_\_\_ If yes, how long\_\_\_\_\_

Do you interact with them? Yes \_\_\_ No \_\_\_

<b>Alcohol / Drug History</b>	<b>YES</b>	<b>NO</b>	<b>MAYBE</b>
1. Do you drink alcoholic beverages?	___	___	___
2. Have you or a family member ever been concerned about your alcohol usage?	___	___	___
3. Does or has your mother or father had an alcohol / drug problem? M ___ F___	___	___	___
4. Do you have a history of drug abuse?	___	___	___
5. Have you or a family member ever been concerned about your drug usage?	___	___	___
6. Do you smoke cigarettes?	___	___	___

<p><b>Church</b></p> <p>What is your church background? _____</p> <p>Do you attend church now? _____ How often? _____</p> <p>Name of current church _____</p> <p>If yes: Are you involved in any ministries? _____</p>
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<p><b>Hobbies</b></p> <p>What are your hobbies?</p> <p>_____</p> <p>What do you do for fun?</p> <p>_____</p>
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