

# lifeWORKS

COUNSELING CENTER

A MINISTRY OF  Longfellow BAPTIST CHURCH

## CLIENT INFORMATION FORM

### About You:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Gender: Male or Female (circle)

City/ST: \_\_\_\_\_ Marital Status: (circle)

Zip: \_\_\_\_\_ single married divorced widowed

Telephone: (h) \_\_\_\_\_ Occupation: \_\_\_\_\_  
(c) \_\_\_\_\_

Employer: \_\_\_\_\_

Is it ok to leave a message at these numbers?

Yes \_\_\_\_ No \_\_\_\_

Email: \_\_\_\_\_

### About Your Family:

Spouse: \_\_\_\_\_ Children: Natural-born, stepfamily, or adopted

Years Married: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Spouse Current Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Employer: \_\_\_\_\_

Your parents: Married Divorced

Mother: Living Deceased

Father: Living Deceased

Your Siblings:

Please indicate how many of each:

Brothers \_\_\_\_\_ Sisters \_\_\_\_\_

How would you describe the quality of your relationship with them? \_\_\_\_\_  
\_\_\_\_\_

What # child are you? 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, baby, etc.  
\_\_\_\_\_

Age when you left home?  
\_\_\_\_\_

How would you describe the quality of your relationship with them? \_\_\_\_\_  
\_\_\_\_\_

Distance (miles) from parents now:  
\_\_\_\_\_

**About your Medical History:**

Family Physician/PCP: \_\_\_\_\_

Phone #: \_\_\_\_\_

Your height: \_\_\_\_\_ weight: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Any RX taken daily? Please list:

Medication	Dosage	Times per day
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Emergency Contact:**

Name: \_\_\_\_\_

Phone : \_\_\_\_\_

Relationship to you: \_\_\_\_\_

List any recent surgeries or illnesses we should be aware of:

\_\_\_\_\_

**About Your Desire For Counseling:**

Did you receive a referral? Yes No

From whom? \_\_\_\_\_

Relationship to you? \_\_\_\_\_

Reason you are seeking counseling today:

\_\_\_\_\_

\_\_\_\_\_

Desired outcome:

\_\_\_\_\_

\_\_\_\_\_

Have you ever received professional counseling before? Yes No

If so, for what reason? \_\_\_\_\_

\_\_\_\_\_

Approximately how many sessions? \_\_\_\_\_

Name of counselor: \_\_\_\_\_

Last visit? \_\_\_\_\_

Outcome? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**About Your Religious Affiliation:**

Are you affiliated with a particular church or denominational group? Yes No

If so, which one? \_\_\_\_\_

City/State: \_\_\_\_\_

Are you actively involved? Yes No

Please give one sentence that describes your religious experience:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I, \_\_\_\_\_, certify that the information contained herein is complete and accurate to the best of my knowledge. I voluntarily consent to the counseling that I receive from LifeWorks Counseling Center.

I understand that LifeWorks is a "Fee for Service Agency" and that there is a 24-hour cancellation policy. All fees are due when services are rendered. Appointments cancelled within the 24-hour period before scheduled appointment will be charged the full fee for service.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date