RestoreMinistries
counseling – teaching – training

# Client Information Form

**GENERAL INFORMATION** **TODAY'S DATE**_____

NAME_____

ADDRESS_____

**Responsible Party (if different from above)**

NAME_____

ADDRESS_____

**REFERRAL SOURCE**

How did you hear about us? _____

If you were referred to us by a specific person, do we have your permission to thank them? ❑Yes ❑No

Name of Referral source (if applicable): _____

Preferred? Leave Message?

HOME PHONE:_____ ❑ Y ❑ N ❑

CELL PHONE:_____ ❑ Y ❑ N

❑ WORK PHONE:_____

❑ Y❑ N ❑ EMAIL AD-

DRESS:_____ Would you like to receive our newsletter? _____

DOB_____/_____/_____ AGE_____ ❑MALE ❑ FEMALE

EMPLOYER_____

JOB TITLE/POSITION_____

HIGHEST EDUCATION LEVEL ATTAINED,WHERE_____

MARITAL STATUS ❑Single ❑Married ❑Divorced ❑Separated ❑Widowed ❑Committed Relationship RACIAL IDENTITY ❑American Indian ❑Asian ❑African-American ❑Caucasian ❑Hispanic ❑Middle Eastern

RELIGIOUS/DENOMINATIONAL Preference (if applicable): _____

MEMBER OF A CHURCH? Yes___ No___ If Yes, WHAT CHURCH_____

Name of Pastor, Minister, or member of the Clergy_____

EMERGENCY CONTACT

_____

Name Contact # Relationship to you

**SPOUSE** # of Years Together: _____

NAME_____ DOB_____AGE_____

HOME PHONE_____CELL_____WORK_____

EMPLOYER_____

JOB TITLE/POSITION_____

HIGHEST EDUCATION LEVEL ATTAINED_____

EMAIL _____

**CHILDREN**

| Name | Sex | Age | Additional Pertinent Information (if any) |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**HOUSEHOLD'S TOTAL INCOME**

____ $0-60,000 ____ $60-79,999 ____$98-99,999 ____$100,000 or more

**PRESENTING PROBLEM**

What brings you to counseling at this time?

_____

_____

_____

_____

_____

Have you (or your family members) ever been involved in counseling? ❑Yes ❑No

If yes, with whom?_____ When?_____ Reason(s):_____

Are you in treatment with another counselor at this time? ❑Yes ❑No

If yes, with whom? _____ Reason_____

Have you ever been admitted to an inpatient or outpatient treatment program? ❑Yes ❑No

If so, where?_____ Dates of treatment _____

Reason for treatment _____

**MEDICAL CONTACT/HEALTH CONDITIONS**

Name of Primary Physician_____

Phone_____

Date of Last Physical_____

Date of Last Visit_____

Known diagnoses (physical and/or Psychological)_____

Name of Psychiatrist (if applicable) _____ Phone_____

Please list all prescribed medications (Medication, Dosage, Frequency, & Name of Prescribing Physician)

_____

_____

_____

Check which of the following you use, and please note the amount and frequency of each:

❑ Caffeine ❑Coffee ❑Sodas ❑Other drinks ❑Pills/Supplements

❑ Alcohol/Adult Beverages_____

❑ Tobacco_____

**FUTURE APPOINTMENTS**

**Should we need to contact you regarding your future appointments, please indicate how we may do this if you are not available when we call. Initial all that apply.**

_____ Leave appointment time on answering machine/voicemail

_____ If no answering machine, leave appointment time with _____

_____ Leave a message with callback number requesting you contact Restore Ministries

_____ Email or Text appointment information