

## Client Information Form

Client's Last Name	Minor Y or N	Client's First Name	Middle Initial	Birth Date (mm/dd/yyyy)
Street Address		City	State	Zip
Home Phone # ( )		Work Phone # ( )	Cell Phone # ( )	Age
If client is a minor, Parent's Last Name		First Name	Is it ok to leave a message at these numbers? <input type="checkbox"/> Yes <input type="checkbox"/> No, please specify	
Email Address		Occupation	Employer	
Partner/Spouse Last Name		First Name	Age	Phone Contact Numbers – Cell/Work
Are you a returning client? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, previous counselor's name	Type of Therapy	Approximate date last seen
Children or Children Other than Client <input type="checkbox"/> Yes <input type="checkbox"/> No		Please provide: NAMES, AGES, GENDER, DATE OF BIRTH, RACE/ETHNICITY		

If applicable, who has legal custody?		If applicable, who has physical custody?	
Last Name of Other Parent/Leg. Guard	First Name	Birth Date (mm/dd/yy)	Age
Street Address	City	State	Zip
Home Phone # ( )	Work Phone # ( )	Cell Phone # ( )	Occupation

Where did you hear about Anthropos Counseling?	Who referred you to us?
Please, take a moment and on the backside tell us a little about the problems you are presenting for counseling.	Please, take a moment and on the backside tell us about your goals for treatment.

Physician's Last Name	First Name	Phone Number ( )
Other treating mental health professional Last Name	First Name	Phone Number ( )
Street Address	City	State      Zip

Emergency Contact's Last Name	First Name
Street Address	City      State      Zip
Home Phone # ( )	Work Phone # ( )      Cell Phone # ( )

Client Name \_\_\_\_\_

Client Code \_\_\_\_\_

