CLIENT INFORMATION

Last Name	First Name	Date of Birth

Home Address	City	State	Zip Code

Telephone Numbers: _____ _____ _____
Home Cell Work

Preferred Contact Number ❑ Home ❑ Cell ❑ Work
May we leave a message at: Home ❑Yes ❑No Cell ❑Yes ❑No Work ❑Yes ❑No

_____
Email Address*

_____ _____
Occupation Employer's Name

Partner/Spouse Last Name	Partner/Spouse First Name	Date of Birth

Home Address	City	State	Zip Code

Telephone Numbers: _____ _____ _____
Home Cell Work

Preferred Contact Number ❑ Home ❑ Cell ❑ Work
May we leave a message at: Home ❑Yes ❑No Cell ❑Yes ❑No Work ❑Yes ❑No

_____
Email Address*

_____ _____
Occupation Employer's Name

*PLEASE NOTE: We will not share your email address with anyone not affiliated with Inner Peace Pastoral Counseling.

Your Current Relational Status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Engaged ❑ Dating
❑ Widowed For how long? _____

Name(s) of Child/Children	Age	Living at home?
_____	_____	❑Yes ❑No
_____	_____	❑Yes ❑No
_____	_____	❑Yes ❑No
_____	_____	❑Yes ❑No

Have you ❑ previously worked with or are you ❑ currently working with (check one) another therapist?

If so, what is the name of the therapist: _____

When was the last time you saw this therapist? _____

Approximately how long did this therapeutic relationship last? _____

Has your spouse/partner ❑ previously worked with or is s/he ❑ currently working with (check one) another therapist?

If so, what is the name of the therapist: _____

When was the last time s/he saw this therapist? _____

Approximately how long did this therapeutic relationship last? _____

What are the reasons for you considering therapy at this time? _____

_____

Please list all of the prescribed medications you are currently taking. Include those of your spouse/partner if s/he will be attending therapy with you.

Client (check one)	Medication	Dosage	Prescribing Physician
❑ Self ❑ Spouse/Partner	_____	_____	_____
❑ Self ❑ Spouse/Partner	_____	_____	_____
❑ Self ❑ Spouse/Partner	_____	_____	_____

Are you and/or your spouse/partner currently being treated by a physician for any medical conditions? If so, please provide a brief description. _____

_____

_____.

Has anyone in your or your spouse/partner's immediate or extended family ever been treated or hospitalized for substance abuse, addictive or compulsive disorders, or any other psychiatric conditions? If so, please provide a brief description. _____

_____

_____.

Who, other than your spouse/partner, should be notified in case of an emergency?

_____	_____	_____	
Last Name	First Name	Phone #	
_____	_____	_____	_____
Street Address	City	State	Zip Code

Relationship: _____

How did you learn about Inner Peace Pastoral Counseling, PLLC?

❑ Referral from friend/family ❑ Referral from physician/therapist ❑ Phonebook ❑ Internet

❑ Other _____

May we send a note of gratitude to the person who referred you? ❑Yes ❑No

May we include your name in the note? ❑Yes ❑No

I hereby attest that the information provided above is current and accurate to the best of my knowledge.

_____
Date

_____	_____
Client Signature	Please print your name
_____	_____
Client Signature	Please print your name