Client Information Form

Margie Segress, MA, LMHC

www.MargieSegress.com *425.829.3196* *margiesegress@gmail.com*

Name: _____ Date: _____

Address: _____

Date of Birth: _____ Age: _____ Occupation: _____

Phone: _____ Email Address: _____

Preferred Method of Contact: ☐ *Email* ☐ *Phone* ☐ *Text*

Marital / Relationship Status: _____

Emergency Contact: _____
(name / relationship /contact info)

Health / Medical Information

Are you currently under medical care? **Y / N**

If so, for what purpose: _____

Prescription / Non-prescription medications: _____

_____

Do you smoke? **Y / N**

Do you drink alcohol? **Y / N** If yes, frequency / amount: _____

Do you use recreational drugs? **Y / N**

If yes, type / amount / frequency: _____

Counseling Goals

Previous experience under care of a psychiatrist, psychologist, counselor? **Y / N**

If yes, for what reason (and/or diagnosis): _____

What are you hoping to gain from counseling? _____

_____

Additional information that would be helpful for me to know:

_____

How did you hear about me? _____

Family Information

	name	*living?*	*age*	*marital status*	*significant issues*
mother					
father					
step-parents					
siblings					
children					
spouse / partner					