

Counseling Services Application—

Personal Information					
First Name		Middle Initial	Last Name		Today's Date
Street Address			City	Zip	
Birth date	Sex: (Please Circle) Male Female		Occupation:	Employer:	
Home phone number:		Cell phone number:		Work phone number:	
Email Address:			Preferred method of receiving contact from me?		
List present or previous health problems:			List any medications you are currently taking:		
<input type="checkbox"/> Spouse <input type="checkbox"/> Parent Information (if Applicable)					
First Name		Middle Initial	Last Name		Marriage Date
Address (if different from above)			Phone # (if different from above)		
Birth date	Sex: (Please Circle) Male Female		Occupation:	Employer:	
Email Address:			Can I contact you via email? (Please Circle) YES NO		
List present or previous health problems			List any medications you are currently taking		
Children's Information (Please list all children)					
Name	Birth date	Lives w/ you?	Name	Birth date	Lives with you?
Other Information					
What do you hope to change or accomplish by seeking help at this time?					
List any agencies or other professionals who have provided you counseling services in the past: (Include inpatient and hospitalizations as well)					
Signature			Signature		

