Client Background Information

Name: ____

Partner Name: ____

Street Address: ____

City: ______________________ State: __________ Zip: __________

Phone Number(s): ____

Email addresses: ____

____

Length of Relationship: ____

Names of Children & Ages: ____

____

Occupations: ____

Have you been to therapy before? ____

If so, how long ago? __________ With whom? ______________________

What brings you to therapy now? ____

____

____

____

____

What do you hope to get out of therapy? ____

____

____

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Client Background Information

What medications are you taking?

How often do you drink alcohol?

What else would you like me to know about your relationship:

For Office Use	Date:
Diagnostic Codes:	
Name on Receipts:	Referred By:

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