# BACKGROUND INFORMATION FORM

**CLIENT INFORMATION** Name _____

Date of Birth _____ Age _____ SSN _____

Address _____

(City) (State) (Zip code)

Telephone Numbers

Home _____ O.K. to leave a message? Y N

Work _____ O.K. to leave a message? Y N

Cellular _____ O.K. to leave a message? Y N

Years of School Completed _____ Occupation _____

Name of Employer/School _____

Marital Status _____ Length of Relationship _____

**Spouse's/Partner's** Name _____ Age _____

**Or Parent's if relevant** Date of Birth _____ SSN _____

Years of School Completed _____

Occupation _____

Place of Employment _____

Children's Names and Ages _____

_____

_____

In case of emergency, please contact _____ Telephone _____

Previous Counseling? _____ When? _____

With Whom? _____

Who referred you here for counseling? _____

Personal Physician(s) _____

What did you see your physician for? _____

_____

Please list all medical conditions. _____

_____

Please list all (if any) medications and dosage presently used. _____

_____

_____

Please outline the present problem as you see it. _____

_____

Signature of person completing this form _____ Date _____