

# Alicia Brown Counseling

## Client Information Form

Please provide the following information so that your first session can be as beneficial as possible. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as our counseling. Please print out this form and bring it to your first session or allow yourself time prior to your appointment to complete the form in the office.

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Name of parent/guardian (if you are a minor): \_\_\_\_\_  
(Last) (First) (Middle Initial)

Client Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Marital Status:  
 Never Married  Partnered  Married  Separated  Divorced  Widowed

Date of Wedding: \_\_\_\_\_ Date(s) of Separation/Divorce: \_\_\_\_\_

Please list children & their ages: \_\_\_\_\_

Local Address: \_\_\_\_\_  
(Street and Number) (City & Zip)

Home Phone: ( ) \_\_\_\_\_ May I leave a message?  Yes  No

Cell/Other Phone: ( ) \_\_\_\_\_ May I leave a message?  Yes  No

Personal E-mail: \_\_\_\_\_

May I email you about scheduling appointments?  Yes  No

\*Please be aware that while email is secure, it is possible that confidentiality may be compromised.

Emergency Contact Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred by: \_\_\_\_\_

Are you currently receiving mental health services elsewhere?  Yes  No

If yes, name of provider: \_\_\_\_\_

Have you ever had previous counseling or psychotherapy?

No  Yes, list Previous counselor's name \_\_\_\_\_