LIGHT COUNSELING, INC.
CLIENT INFORMATION

Name_________________________ What do you prefer to be called ____________
Who referred you to Light, or how did you find out about us? ______________________

Address____
Street Address City State Zip Code
Birthdate ______________ Age _____________

Home Phone __________________Work ________________ Cell _____________

Parent/ Guardian ____________________________ Relationship _______________

Current Relationship Status: ( ) Single ( ) Dating ( ) Engaged ( ) Married ( )Divorced
( ) Separated ( ) Widowed ( ) Remarried.
Are you content with your current status ? ( ) Yes ( ) No. If No, briefly explain:

____

Spouse's Name & Age _______________________ Number of Years Married ________
Number of marriages for client _________ for spouse ________ Any Children ( )Yes ( ) No

Name of Children	Sex/Age	Name	Sex/Age
1. ______________________________		4.______________________________	
2. ______________________________		5.______________________________	
3. ______________________________		6.______________________________	

Who presently lives in your household? _____________________________________

Emergency Contact Name/ Relationship ____________________Phone ___________

Education Information
Education Completed ( ) 9 ( ) 10 ( ) 11 ( ) 12 ( ) GED: College ( ) 1( )2 ( )3 ( ) 4 Other _____
Currently in school? Yes No. If yes, what school and what grade? ________________

Place of Employment ____________________________ Job Title ______________
Have you ever been unable to work? ______ If yes, explain ______________________
Religious Background/ Involvement? Describe: ______________________________
Are there any religious, cultural or ethnic issues we need to be aware of? ______________
If yes, describe: ____

Have you ever been to a counselor before? If yes, Who, what year, and why it ceased: ______

____

Medical information

Name of Medications/ Dosage/ Why Prescribed: ____

____

Name of Primary Physician or other treating Physicians, their area of specialty and what (if anything) you are being treated for: ____

List any Conditions, Illnesses, traumas, surgeries or hospitalizations: ______________________

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Please circle any of the symptoms that apply:

Headaches, decrease in appetite, increase in appetite, intestinal problems, Difficulty sleeping, Fatigue, Low energy, Rapid heartbeat, Difficulty breathing, tension, stomach problems, Hearing voices, Hearing noises, Seeing things, Depression, Anxiety, Hopelessness, Eating Disorder, Shyness, Guilt, Stress, Panic, Fears, Grief, Unwanted thoughts, Bad Dreams, Finances, Making Decisions, Apathy, Terminal Illness, Anger, Racing Thoughts, Impulsiveness, Loss of Control, Legal Matters, Marital Problems, Verbal Abuse, Sexual Abuse, Physical Abuse, Compulsiveness, Recent Loss, Career Choices, Sexual Problems, Drugs, Alcohol Abuse, increase in smoking, excessive caffeine intake, Concentration, Memory, Self-Control, Temper, Other? ____________________________

Current Problem (s) Reasons (s) for coming to Light Counseling? ________________________

____

What prompted you to come for counseling now? ____________________________________

Have you ever been hospitalized for emotional/mental problems? If yes, when & where? _____

____

Have you ever attempted suicide? ( ) Yes ( ) No If yes, how long ago? __________________

Are you currently having any suicidal thoughts? ( ) Yes ( ) No

By signing below, I hereby give permission for the identified patient to receive counseling at Light Counseling, Inc.

____ ____________________

Patient's Signature Date

____ ____________________

If Patient is under 18, signature of Parent/ Guardian Date

____ ____________________

Therapist's Signature Date