Westport Counseling & Therapy

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CLIENT INFORMATIONAL SHEET

Name _____ (First) _____ (Last) _____ (Nickname)

Age _____ Date of Birth _____ (MM / DD / YYYY) Gender _____

Address _____ (Street)

_____ (City) _____ (State) _____ (Zip)

Phone No. _____ May we leave a voicemail/text? ☐ Yes ☐ No

Email _____ May we leave an email? ☐ Yes ☐ No

Insurance Provider _____ ID No. _____

Provider Phone No. (on back of card) _____

How did you hear about Westport C&T?

☐ Family ☐ Insurance List ☐ Internet Search

☐ Friend ☐ Psychology Today ☐ Word of Mouth

☐ Other _____

Is this your first time in therapy? ☐ Yes ☐ No If no, when was your last session? _____

Who was your previous therapist? _____

Partner/Spouse Name _____

Relationship Status _____ Length of Relationship _____

Do you have children? ☐ Yes ☐ No Number of Children _____ Age Range _____

Who lives in your household? _____

Ethnic/Cultural Background _____ Native Language _____

Religious/Spiritual Orientation _____ Sexual Orientation _____

(continues on back)

Educational Background _____

Professional/Employment Status _____

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1. Are you currently under a physician's care? ☐ Yes ☐ No

If yes, why? _____

Name of Physician _____ Location _____

2. Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list them here: _____

_____

Emergency Contact Name _____

Relationship _____ Phone No. _____

Please briefly state why you are seeking therapy at this time:

_____

_____

_____

Please check any issues that apply to you:

☐ Abuse	☐ Career	☐ Life Transition	☐ Self-Esteem
☐ Addiction	☐ Depression	☐ Multicultural	☐ Self-Harm Behaviors
☐ ADHD	☐ Family Conflict	☐ New Parent	☐ Sexual Identity
☐ Anger	☐ Grief and Loss	☐ Premarital	☐ Stress
☐ Anxiety	☐ Legal Issues	☐ Relationship Issues	☐ Trauma

I hereby certify that the above information is true and accurate to the best of my knowledge.

_____
Print Name

_____ _____
Signature Date