

Laurie Barton MA, LPC

Client Information Form  
(Note: This information will be kept in confidence)

New client     Returning client

**PERSONAL INFORMATION:**

Please mark one: Mr. \_\_\_\_ Ms. \_\_\_\_ Mrs. \_\_\_\_ Dr. \_\_\_\_

Name: \_\_\_\_\_

Name you would like to be addressed by: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Contact:

\_\_\_\_\_ (Work)                  \_\_\_\_\_ (Home)                  \_\_\_\_\_ (Cell)

Best Way to Reach You: \_\_\_\_\_

Best time to contact you: \_\_\_\_\_

Is it okay to contact you at your home? Yes \_\_\_\_ No \_\_\_\_

Is it okay to leave a message at your home? Yes \_\_\_\_ No \_\_\_\_

Is it okay to leave a message at your workplace? Yes \_\_\_\_ No \_\_\_\_

Is it okay to leave a message on your cell phone? Yes \_\_\_\_\_ No \_\_\_\_\_

Is it okay to text message you on your cell phone? Yes \_\_\_\_\_ No \_\_\_\_\_

Is it okay to e-mail you? Yes \_\_\_\_\_ No \_\_\_\_\_

Is it okay to mail information to your home? Yes \_\_\_\_\_ No \_\_\_\_\_

Email address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Ethnic Group:

African-American: \_\_\_\_\_ Hispanic: \_\_\_\_\_ White: \_\_\_\_\_

Native American: \_\_\_\_\_ Asian: \_\_\_\_\_ Other: \_\_\_\_\_

Are you a US citizen? Yes \_\_\_\_\_ No \_\_\_\_\_

If not, how long have you lived in the US? \_\_\_\_\_

Your Religion: \_\_\_\_\_

**CURRENT LIVING SITUATION:**

**Marital Status:**

Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_

Divorced \_\_\_\_\_ Separated \_\_\_\_\_ Other \_\_\_\_\_

**Composition of present household (check all that apply):**

Living alone: \_\_\_\_\_ Living w/ Parent: \_\_\_\_\_ Living w/ Spouse: \_\_\_\_\_

Living w/ Romantic Partner: \_\_\_\_\_ Living w/ In-Laws: \_\_\_\_\_

Living in Group House: \_\_\_\_\_ Living w/ roommate \_\_\_\_\_

Other (please describe) \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Number of children: \_\_\_\_\_

Ages: \_\_\_\_\_

Number of children living: \_\_\_\_\_ Deceased: \_\_\_\_\_

Number of children in household: \_\_\_\_\_

**FAMILY OF ORIGIN:**

**Is your mother living? \_\_\_\_\_ Mother's age: \_\_\_\_\_**

**If not, what was your age at mother's death: \_\_\_\_\_**

**Your mother's age at death: \_\_\_\_\_**

**Is your father living? \_\_\_\_\_ Father's age: \_\_\_\_\_**

**If not, what was your age at father's death: \_\_\_\_\_**

**Your father's age at death: \_\_\_\_\_**

**Number of Brothers: \_\_\_\_\_ Number of Sisters: \_\_\_\_\_**

**Your position in the Family:**

**Eldest: \_\_\_\_\_ Middle: \_\_\_\_\_ Youngest: \_\_\_\_\_**

**Twin: \_\_\_\_\_ Adopted: \_\_\_\_\_ : Only child: \_\_\_\_\_**

**Are all of your siblings living? (If not, your age when your sibling(s) died. please explain):**

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**EDUCATION:**

**Your highest education level attained (check one):**

**Elementary school:** \_\_\_\_\_ **Middle school:** \_\_\_\_\_

**High school:** \_\_\_\_\_ **Trade school graduate:** \_\_\_\_\_ **(Describe)**

**Some college:** \_\_\_\_\_ **College graduate:** \_\_\_\_\_  
**(School, Degree, and Major)**

**Some graduate studies:** \_\_\_\_\_  
**(School, Program, and Major)**

**Master's Degree:** \_\_\_\_\_  
**(School, Degree, and Major)**

**Doctorate, J.D. or M.D.:** \_\_\_\_\_  
**(School, Degree, and Major)**

**EMPLOYMENT:**

**Occupation:** \_\_\_\_\_

**Current Employment:**

**Fulltime:** \_\_\_\_\_ **Part-time:** \_\_\_\_\_ **Self-employed:** \_\_\_\_\_

**Unemployed:** \_\_\_\_\_ **Student:** \_\_\_\_\_ **Homemaker:** \_\_\_\_\_

**Current Income:** \_\_\_\_\_ **Are you a veteran?** \_\_\_\_\_

**MEDICAL/MENTAL HEALTH:**

**Name of Personal Physician:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Date of last physical:** \_\_\_\_\_

**Medical Conditions:  
(past/current):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Are you taking any medications?** \_\_\_\_\_

**If so, what types?** \_\_\_\_\_

\_\_\_\_\_

**Previous mental health or emotional issues:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you ever attempted suicide before? Yes \_\_\_ No \_\_\_**

**Have you recently considered or are you recently considering committing**

**suicide? Yes\_\_\_ No \_\_\_**

**Have you been to therapy before? Yes \_\_\_No \_\_\_**

**If yes, when: \_\_\_\_\_**

**What issue(s) did you address?\_\_\_\_\_**

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**Reason for seeking therapy at this time:\_\_\_\_\_**

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**Additional important information you would like me to know: \_\_\_\_\_**

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**EMERGENCY CONTACT:**

**Name:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**Relationship to you:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**REFERRAL:**

**Where did you hear about me?** \_\_\_\_\_

\_\_\_\_\_

**Referral Name:** \_\_\_\_\_

**Did you come here voluntarily? Yes:** \_\_\_\_\_ **No:** \_\_\_\_\_

**48-HOUR CANCELLATION POLICY:**



**I have a 48-hour cancellation policy for appointments. If you need to cancel or reschedule your appointment, I will not charge you for it if you give me a full 48-hours' notice. Without such notice, the price of the full appointment fee will be charged to you.**

**Please sign here to indicate that you have read and understand this policy:**

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*Printed Name*

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*Client Signature*

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*Date*

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*Parent/Guardian Signature if client is a minor*

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*Date*