SOLACE
COUNSELING AND ANXIETY CENTER

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Client Information Form
(Adult)

Client Name: _____ DOB: _____

Spouse's Name: _____ DOB: _____

Children's Names and Ages: _____

_____

Address: _____ City: _____State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail address: _____

Primary Care Physician: _____

Emergency Contact and Phone: _____

List of current medications: _____

Reason for coming today: _____

(Please circle any that apply)

Stress	Sadness	Anger	Rage
Nervous	Grief	ADD/ADHD	Shortness of Breath
Poor Concentration	Suicide Attempt	Trauma	Incarceration
Tension	Fatigue	Obsessions	Anxiety
Depression	Suicidal Ideation	Sleep Disturbance	Nightmares
Tics	Impulsivity	Dizziness	Headache
Appetite Changes	Frequent Crying	Sexual Concerns	Phobias
Hyperactivity	Compulsions	Drug/Alcohol Use	Hallucinations
Delusions	Homicidal Ideation	Distractibility	Low Self-Esteem
Apathy	Forgetfulness	Failures	Extreme Fears
Confusion	Despair	Guilt	Shame
Hopelessness	Withdraw from Others	Loneliness	Hurt

By signing below, I am verifying the personal information on this sheet is accurate.

Client/Guardian Signature:_____Date_____