TAMPA COUNSELING AND WELLNESS

CLIENT INFORMATION FORM

Name: _____ Todays Date: _____/_____/_____

Birth Date: _____/_____/_____ Age: _____ Gender: _____

Sexual Orientation: _____ RelationshipStatus:_____

Race: _____

Religion: _____ Ethnicity: _____

Languages: _____

Address:

_____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____- Voice Message OK: ☐Yes ☐No Text Message OK: ☐Yes ☐No

Email:

CURRENT ISSUE:

Reason for seeking services:

_____

_____

_____

When did the issue(s) and/or symptoms begin?

_____

What caused/contributed to your issue(s) and/or symptoms?

_____

_____

Have you received mental health services in the past? ☐No ☐Yes

If yes, please provide:

Name of provider or facility: _____

Location (city/state): _____

Length of treatment:

_____

Reason for treatment: _____

MEDICAL/HEALTH HISTORY

Name of primary care physician/doctor: _____

Address: _____ Phone: _____

Please list any health problems you are currently experiencing or have been diagnosed with in the past:

_____

EDUCATION: _____

Highest grade completed: _____ Degree type: _____

Major(s): _____

CAREER/OCCUPATION

Current Occupation: _____ Title: _____

Employer: _____ Years: _____

PET INFORMATION

Type (*dog, cat, etc.*): _____

Breed: _____ Age: _____ Weight: _____

How does your pet help you cope with your situation?

_____

_____

Printed Name

_____

Client Signature

_____

Date