Margaret Piela, LMHC, PLLC

Confidential Client Information

Personal Information: **Today's Date: _____**

Last Name: _____ First _____ Middle Initial _____

Address: _____

City: _____ State_____Zip _____

Occupation _____ Highest Level of Education _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

But Prefer you contact me at _____or Email Address: _____

Birth Date: _____ Age: _____ Sex: Male _____ Female _____

Marital Status: Single ____ Married ____ Partnered ____ Divorced ____ Separated ____ Engaged ____

How long _____ If married/partnered, spouse/partner's name: _____

Is your spouse/partner supportive of you seeking counseling?_____

Do you have children? _____ Ages: _____

In case of emergency please notify: _____

Medical History:

Are you currently under medical care? ____ If yes, please indicate reason _____

_____

Physician's Name _____ Phone: _____

Do you (or spouse if marriage counseling) take any prescription medications? _____ If yes, what are they?

_____

Other significant medical history _____

_____

Counseling History:

Have you previously seen a counselor/therapist/psychologist/psychiatrist? _____

Name/Date/Location _____

When was your last appointment with any of the above? _____

Have you ever attempted suicide? _____ Have any family members attempted suicide? _____

In your own words, write why you are seeking counseling: _____

_____

_____

How long have these concerns been causing you distress? _____

By whom were you referred to this counseling center? _____

How do you hope counseling will help? _____

_____

Is there anything else you feel that is important for the counselor to know: _____

_____

_____