Morning Light Counseling Services
Client Information Sheet

Name: Last	First	M.I.	Age	Date of Birth

Name: Last	First	M.I.	Age	Date of Birth

Address	City	Zip

SS# _____

_____ OK to call? Yes No OK to leave msg? Yes No
Contact Number

Single Cohabitating Married Separated Divorced Widowed (circle one)

Spouse's Name (if applicable)_____

Children (if applicable)

Name	Age	Name	Age

Name	Age	Name	Age

Whom may be contacted in case of emergency?_____
Name Phone #

Psychological & Medical Have you experienced prolonged or recurring:

Insomnia___ Nightmares___ Excessive Sleep___Appetite Changes__ Anxiety___
Phobias___ Depression___ Mental or Nervous Condition___Stomach Problems___
Headaches___ Heart Problems___ Sexual Disorder___ Alcoholism___ Drug Abuse ___
Physical or Sexual Abuse ___ Schizophrenia ___

Current Medical Problems:_____

Current Medications:_____ _____
Medication For What?

_____ _____
Medication For What?

Have you ever had previous psychological treatment, counseling or therapy? Yes No

_____ _____

Where? When?

_____ _____

Where? When?

Have you ever had suicidal thoughts or attempted suicide? Yes No

Family of Origin

Is mother living? Yes No_____ Is father living? Yes No_____

Name Age Name Age

Brother or Sisters? Yes No_____ _____

Name Age Name Age

_____ _____

Name Age Name Age

Presenting Problem

Please note your goals for therapy:

Who is financial responsible for these services:

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on both sides of this form and have completed all answers. I certify this information is true and correct to the best of my knowledge and will notify you of any changes in the above information.

_____ _____

Client's signature (parent/guardian if minor) Date