Client Information Form

Name: Phone: (home) (cell)

Address: City, State, Zip

Email:

The following information is helpful, but not required:

M F

Gender: Date of Birth: Age:

1 2 3 4 5 6 7 8 9 10

Occupation Stress Level At This Time *10 being the most*

Emergency Contact Name: Relationship: Phone:

Would you like to share what brings you to therapy today?

Previous psychotherapy? YES NO

Anxiety/Depression Meds? YES NO

Suicidal / Hospitalization YES NO

Drug use / Alcohol abuse YES NO

Who makes up your immediate household?

Parents, step-parents, siblings with birthdate year (and death, if applicable)

Signature of Client Date

I hereby consent to receive psychotherapy from Brianna Finney, MA, a counseling resident. Any information shared by the client during these sessions will be held confidential. I do not hold Brianna Finney responsible for my perception of what therapeutic results may or may not take place. I acknowledge and agree that no representations, warranties, or guarantees as to results or cures have been made to me or relied upon by me. I further acknowledge that my relationship is solely with Brianna Finney, and the office of the 921 Group disclaims all responsibility whatsoever for the services received. The information on this page is true to the best of my knowledge.