

Life Matters Counseling  
Kelley Nay, M.S., LMFTA  
(425) 681-9272

1611 – 116<sup>th</sup> Ave. NE, Ste 100  
Bellevue, WA 98004  
(425) 458-9331 fax

## CLIENT INFORMATION FORM

Date \_\_\_\_\_ Driver's License# \_\_\_\_\_ Social Security # \_\_\_\_\_

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Age \_\_\_\_\_ Male / Female \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ OK to Call (circle)? Home Work Cell

Email: \_\_\_\_\_ OK to Email? Yes/No

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

*If client is under 18 years of age:* Name of Parent/Guardian \_\_\_\_\_ Phone \_\_\_\_\_

If patient is dependent child, are custodial parents: Married Separated Divorced Remarried

Referred to Counseling By \_\_\_\_\_

Please describe your purpose for coming to counseling \_\_\_\_\_

## BACKGROUND INFORMATION

Highest Level of Education \_\_\_\_\_ Degree \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

If attending school, school name and area of study: \_\_\_\_\_

Marital Status (circle): Single Married Separated Divorced Remarried

Spouse/Partner's Name \_\_\_\_\_ Age \_\_\_\_\_ M/F \_\_\_\_\_ Occupation \_\_\_\_\_

If married, or in relationship, how long? \_\_\_\_\_ Any previous marriages? Yes/No

If yes, how long \_\_\_\_\_ How long divorced/separated/widowed? \_\_\_\_\_

Parents: (Please list ages)

Mother \_\_\_\_\_ Father \_\_\_\_\_ Stepmother \_\_\_\_\_ Stepfather \_\_\_\_\_

Are you providing care for elderly parents or relatives? \_\_\_\_\_

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Siblings (please list ages): Brothers \_\_\_\_\_ Sisters \_\_\_\_\_

Children/Stepchildren:

Name \_\_\_\_\_ M/F \_\_\_\_ Age \_\_\_\_\_ Live at home? Yes/No

Name \_\_\_\_\_ M/F \_\_\_\_ Age \_\_\_\_\_ Live at home? Yes/No

Name \_\_\_\_\_ M/F \_\_\_\_ Age \_\_\_\_\_ Live at home? Yes/No

Name \_\_\_\_\_ M/F \_\_\_\_ Age \_\_\_\_\_ Live at home? Yes/No

Name \_\_\_\_\_ M/F \_\_\_\_ Age \_\_\_\_\_ Live at home? Yes/No

Name \_\_\_\_\_ M/F \_\_\_\_ Age \_\_\_\_\_ Live at home? Yes/No

Race/Ethnicity (optional) \_\_\_\_\_

Religious/Spiritual Preference (optional) \_\_\_\_\_ Importance: High Moderate Low

**MEDICAL INFORMATION**

History of major illnesses or injuries (please give approximate dates) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Current medical conditions or concerns \_\_\_\_\_

\_\_\_\_\_

Current Medications (Please include both prescription and over-the-counter)

Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____

Amount of alcohol intake/week \_\_\_\_\_

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Do you use recreational or street drugs? Yes/No

If yes, please describe which ones you use and how often? \_\_\_\_\_

Date of last physical \_\_\_\_\_ Are you generally healthy? Yes/No Do you generally sleep well? Yes/No

Do you eat well-balanced meals regularly? Yes/No Do you exercise regularly? Yes/No

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

Physician's Address \_\_\_\_\_

Have you received counseling before? Yes/No If yes, please describe the reason for therapy, the therapist's name, and approximate dates \_\_\_\_\_

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What were the most and the least useful aspects of your prior therapeutic experiences? \_\_\_\_\_

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Is there any additional information you would like me to know? \_\_\_\_\_

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Thank you!

**Office Use Only:**

Fee: \_\_\_\_\_

Informed Consent Received/Signed \_\_\_\_\_

Privacy Statement Received/Signed \_\_\_\_\_