

GRANBERRY COUNSELING CENTERS

Client Name _____ Birth date _____ Age _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ **Work Phone** (____) _____ **Cell Phone** (____) _____
E-mail Address _____ (Please circle your preferred method of communication)
Place of Employment/School _____ **Occupation** _____
Religious preference _____ **Church you attend** _____
Marital Status: Single _____ Married _____(yrs) Divorced _____(yrs) Widowed _____(yrs) Separated _____(yrs)
Spouse Name _____ Birth date _____ Age _____
Home Phone (____) _____ **Work Phone** (____) _____ **Cell Phone** (____) _____
Responsible Party _____ Birth date _____ Relationship to Client _____
Mailing Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ **Work Phone** (____) _____ **Cell Phone** (____) _____
Emergency Contact _____ Relationship to Client _____
Home Phone (____) _____ **Work Phone** (____) _____ **Cell Phone** (____) _____

List all others living in the client's home:

Name	Birth date & Age	Relationship (ex. - son, daughter)	School/Place of Employment

Check all the items that describe the concerns that bring you to counseling:

Hopelessness Grief School Fear Violence
 Guilt Pre-Marital Loneliness Work Anger
 Parenting Anxiety Sexual Issues Depression Religious Issues
 Marital Issues other (please specify) _____

List current medical problems/medications of any family member:

Have you ever received psychiatric or psychological help or counseling of any kind before? Yes No

How did you hear about Granberry Counseling Centers? _____

Household Income:

below \$30,000 \$30,001 to \$40,000 \$40,001 to \$50,000
 \$50,001 to \$60,000 \$60,001 and up

Counselor Use Only:

Date: _____ I/C/F/CH _____ M/F _____ Case # _____