GRANBERRY COUNSELING CENTERS

Client Name____ Birth date ____________________

Responsible Party ____ Birth date ____________________

Mailing Address___________________________________City____________________State____ Zip_________

Home Phone __________________ Work Phone ____________________ Cell /Pager ____________________

Place of Employment ____ Occupation ____________________

Religious preference ________________________ Church you attend _________________________________

Marital Status: Single Married Divorced Widowed Separated

Spouse Name ____ Birth date ____________________

Place of Employment ____ Work Phone __________________

List all others living in your home:

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

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

_____ Anger _____ Anxiety _____ Depression _____ Fear _____ Grief

_____ Guilt _____ Hopelessness _____ Loneliness _____ Marital Issues ____ Pre-Marital

_____ Parenting _____ Religious Issues _____ Sexual Issues _____ School _____ Work

_____ Violence _____ 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? ____

Additional information requested: (please check all that apply)

Family Annual Income Level

_____ below $20,000 _____ $20,001 to $30,000 _____ $30,001 to $40,000 _____ $40,001 to $50,000

_____ $50,001 to $60,000 _____ $60,001 to $70,000 _____ $70,001 to $80,000 _____ above $80,001

Educational Level

Last Grade Completed _____ High School Diploma/GED _____ College Degree _____ Graduate Degree _____

Counselor Use Only:

Date _______ I/C/F/CH_____ M/F____ B/W/O _____ Case # _________________

Rev. 1/16/2006