CLIENT HISTORY

Instructions: To assist in getting some information about you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

PERSONAL INFORMATION

FIRST NAME:	**LAST NAME:**	**MIDDLE INITIAL:**	**DOB:** _____ / _____ / _____
GENDER:		**WEIGHT:**	**HEIGHT:**
RACE/ETHNICITY:		**EYE COLOR:**	**HAIR COLOR:**
LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING:		**LIST ANY MEDICAL CONDITIONS:**	

CONTACT

STREET ADDRESS:	**CITY/STATE:**	**ZIP CODE**	**HIGHEST EDUCATION COMPLETED:**
BEST PHONE NUMBER TO REACH YOU:		**ALTERNATE PHONE NUMBER:**	
CAN WE LEAVE YOU A VOICEMAIL?			

HISTORY

HAVE YOU RECEIVED COUNSELING OR PSYCHOTHERAPY TREATMENT PREVIOUSLY?		
LOCATION:	**DATES:**	**THERAPIST'S NAME:**

VISIT INFORMATION

DESCRIBE THE REASON FOR YOUR VISIT TODAY:
HOW LONG HAS THIS PROBLEM PERSISTED?
WHAT CONDITIONS MAKE THE PROBLEM WORSE:

Email: mwray@waicounseling.com Telephone: (888) 388-9242 Fax: (248) 479-2578