LEGACY Consortium
Inspiring Greatness | Changing Legacies

NEW CLIENT INFORMATION FORM

Please provide the following information. Services are provided for couples, families & individuals ages 18 yrs & above.
Couples please complete a separate form for each spouse.

Today's Date: / /

Personal Information

Name:			Age:	Sex:
Date of Birth: / /	Race/Ethnic Group: _____ Primary Language: _____ Other Fluent Languages: _____		Home Phone #: OK to leave message? [] Yes [] No Cell Phone #: OK to leave message? [] Yes [] No	
Street Address: Apt#:			Marital Status: (please check one) Never Married: Married: Divorced: Widowed: Separated:	
City:	State:	Zip:	Emergency Contact:	
# of Children:	Their Ages:		Their Phone #:	

Please describe what issues you would like to address:

1. _____

2. _____

3. _____

*****Please attach a copy of your driver's license [and your spouse's if requesting couple's therapy) when you are submitting this Intake Form. This information will be kept confidential and will only be used to confirm your identity if you are scheduled for video-based counseling session.*****

Your Name: _____ ***Date:*** _____

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Education / Employment Information

Last grade completed in school:	Are you employed now? []Yes [] No
Company Name:	Company Phone:
Company Address:	Present Occupation:
Main occupation during past 5 years:	
Describe your education (# of years of school, special training, etc.)	

Spiritual History

Religious Affiliation:	Do you currently attend a place of worship?:
List a Few Words to Describe Your Personal Faith:	
List Those Who Support You Most Spiritually:	
Do you prefer to include spirituality as part of your counseling process? [] No [] If Yes – How?	

General Information

How would you rate your overall physical health? □ Excellent □ Great □ Good □ Fair □ Poor

Do you have any sleep problems? Yes No

If yes, please describe:_____ Please list the names and relationships of the most important people in your life:

1.	4.
2.	5.
3.	6.

Do you have pets? Yes No If yes, please list: _____

Did anyone in your family die before you were 18 years old? [] Yes [] No

Who? _____

How old were you? _____ Other family deaths? _____

Your Name: _____ ***Date:*** _____

Have you ever been abused or assaulted?	YES	NO	DON'T REMEMBER	(Check One)
Did you witness abuse between your parents?	YES	NO	DON'T REMEMBER	(Check One)
Did you witness abuse between parent and child?	YES	NO	DON'T REMEMBER	(Check One)

Describe your current living situation:

_____

List everyone currently living in your home, including family and other:

NAME	AGE	BIRTHDATE	RELATIONSHIP

Please check any of the following strengths you have:

CONFIDENT	HARD WORKER	ORGANIZED	SYMPATHETIC	GOOD LISTENER
DEPENDABLE	SENSITIVE	LOGICAL	LOYAL	GRACIOUS
DECISIVE	RESPONSIBLE	UNDERSTANDING	SENSE OF HUMOR	PATIENT
OTHER				

_____

_____

Are you usually: □ Early □ On Time □ Running Late

Your Name: _____ ***Date:*** _____

Do you exercise regularly? □ Yes □ No

If yes, please describe what you do and how often:

_____

_____

How often do you watch television?

_____

What are your favorite hobbies and sports?

_____

_____

What do you do for fun?

_____

_____

When you treat yourself, what are things you like to do?

_____

_____

What is your idea of a perfect vacation?

_____

_____

How did you hear about me?

_____

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Printed Name: _____ Date: _____

Signature: _____

Printed Name: _____ Date: _____

Signature: _____

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THANK YOU FOR COMPLETING THIS FORM

For office use only

Date of Initial Session*:* _____ **Driver's license received?** *[] yes [ ] no* **ID verified?** *[] yes [] no*

Agreed upon password for phone sessions: _____

5th session update due: _____ New password: _____

10th session update due: _____ New password: _____

15th session update due: _____ New password: _____

_____

Date