



Marcie Edmonds, MC, LPC
Licensed Professional Counselor

CLIENT INFORMATION RECORD

Registration Information & Client Information

All questions contained in this questionnaire are strictly confidential and will become part of your record

Name:		Marital status:	
		<input type="checkbox"/> Single	<input type="checkbox"/> Married
		<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
		<input type="checkbox"/> Widowed	
Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Children: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Living at Home	
		<input type="checkbox"/> Not Living at Home	
Home Address:	City	State:	ZIP
Work Address:	City	State:	ZIP
Home Phone: ()		Work Phone: ()	

Daytime phone number where you wish to be reached regarding appointments. Calls will be discreet, but please indicate any restrictions regarding calls: ()

Client Date of Birth:	Social Security Number:
Party Responsible for Payment:	
Were you referred? <input type="checkbox"/> Y <input type="checkbox"/> N	By Whom?

* **NOTE:** No contact will be made by me with the referral source regarding your decision to engage my services unless you request it.

Employment Status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Not Employed <input type="checkbox"/> Retired
Employer:
Student Status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time School:
What problem or concern brings you to therapy at this time?

What do you hope to accomplish in therapy?

In case of emergency, please contact:
Name: _____ Phone: () _____ Relationship: _____