



## CLIENT INFORMATION FORM

Date:

1. FULL GIVEN NAME(*include other names used*): HOW DID YOU GET YOUR NAME?

2. ADDRESS(*and all previous addresses*):

3. DATE OF BIRTH(*including PLACE, TIME, HOSPITAL NAME*)

4. SOCIAL SECURITY NUMBER:

5. WHO ARE YOU CLOSEST FRIENDS AND FAMILY MEMBERS:

6. WHO DID YOU LIVE WITH GROWING UP:

7. GOOD THINGS ABOUT GROWING UP.WHAT ARE YOU THANKFUL FOR?



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### 8. SIBLING INFORMATION:

	NAME	BIRTHDAY	CONTACT INFO.	NAME
<b>MOM</b>				
<input type="checkbox"/> Bro <input type="checkbox"/> Sis				Dad:
<input type="checkbox"/> Bro <input type="checkbox"/> Sis				Dad:
<input type="checkbox"/> Bro <input type="checkbox"/> Sis				Dad:
<b>DAD</b>				
<input type="checkbox"/> Bro <input type="checkbox"/> Sis				Mom:
<input type="checkbox"/> Bro <input type="checkbox"/> Sis				Mom:
<input type="checkbox"/> Bro <input type="checkbox"/> Sis				Mom:

### 9. GRANDPARENTS INFORMATION:

10. RELATIVES: WHO SHOULD I KNOW ABOUT? TELL ME A STORY ABOUT ONE OF THEM:

11. SPOUSE/ LIFE PARTNER/ SWEETHEART? (ALL OF THEM)

12. HOW DID YOU MEET YOUR SPOUSE/ LIFE PARTNER/ SWEETHEART?



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### 13. SCHOOLS ATTENDED:

1 <sup>st</sup>	_____	2 <sup>nd</sup>	_____	3 <sup>rd</sup>	_____	4 <sup>th</sup>	_____
5 <sup>th</sup>	_____	6 <sup>th</sup>	_____	7 <sup>th</sup>	_____	8 <sup>th</sup>	_____
9 <sup>th</sup>	_____	10 <sup>th</sup>	_____	11 <sup>th</sup>	_____	12 <sup>th</sup>	_____
	_____		_____		_____		_____

GED: \_\_\_\_\_

### 14. JOBS & DATES

15. INVOLVEMENT WITH JUVENILE COURTS?  YES  NO  
IF YES, WHEN AND WHERE?

16. HAVE YOU EVER LIVED IN FOSTER CARE?  YES  NO  
IF YES, WHEN AND WHERE?

17. LIST ALL PROBATION OR PAROLE OFFICERS AND WHERE THEY ARE LOCATED?

18. LIST ALL LAWYERS WHO HAVE REPRESENTED YOU?

19. MILITARY SERVICE  YES  NO  
IF YES, IDENTIFICATION NUMBER:

20. HAVE YOU EVER BEEN EXPOSED TO ANY TOXIC SUBSTANCES?  YES  NO  
IF SO, WHEN?

21. LIST ALL HOSPITALS YOU HAVE BEEN ADMITTED INCLUDING EMERGENCY ROOM VISITS?



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22. HAVE YOU EVER SUFFERED A HEAD INJURY?  YES  NO

IF YES, PLEASE DESCRIBE:

23. DESCRIBE ANY SURGERIES AND WHERE THE PROCEDURE WAS DONE:

24. HAVE YOU EVER DRANK ALCOHOL?  YES  NO

IF YES, TELL ME ABOUT THE FIRST TIME?

25. HAVE YOU EVER USED DRUGS?  YES  NO

IF YES, WHICH ONES? HOW MUCH?

26. DO YOU HAVE A RELGION?  YES  NO

TELL ME ABOUT IT.

27. NAME ANY COUNSELORS OR MENTAL HEALTH PROFESSIONALS?

28. DO YOU TAKE ANY MEDICATIONS PAST OR PRESENT?  YES  NO

IF YES, FOR WHAT?

29. HAVE YOU EVER HAD PROBLEMS WITH YOUR VISION?  YES  NO

30. HAVE YOU HAD PROBLEMS WITH YOUR HEARING?  YES  NO

31. DO YOU HAVE SOCIAL MEDIA (FACEBOOK, INSTAGRAM, WEBSITE, etc)?  YES  NO

Login:

Password:

32. WHO AM I AUTHORIZED TO SPEAK WITH REGARDING YOUR CASE?