ASBELL
HEALTH STRATEGIES

# Client Information Form

Name_____ _____ _____ _____
First MI Last Date of Birth Age SSN

Home Address_____
Street City State Zip

E-Mail Address_____

Telephone #'s_____ _____ _____
Home Work Other / Cell Phone

Do you need restrictions on how we might contact you? ☐ Yes ☐ No

Years of School Completed_____ Degree_____ Occupation_____

Name of Employer/School_____

In case of emergency, please contact_____ Telephone_____

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Relationship Status
- ☐ Married
- ☐ Partnered
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Spouse/Partner Information

Name_____ SSN_____

Age_____ Date of Birth_____

Yrs. of School Completed_____ Occupation_____

Place of Employment_____ Work #_____

Length of Relationship _____

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Children's Names and Dates of Birth _____

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Previous Counseling? Yes No With Whom?_____

Who referred you here for counseling?_____

Personal Physician(s)_____

When did you last see your Physician?_____

Please list all medical conditions_____

_____

Please list all (if any) medications presently used_____

_____

Please outline the present problem as you see it_____

_____

_____ _____
Signature of person completing this form Date

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