

Mary Clare MS Ed, MSW, LCSW-R

277 Alexander Street Suite 300

Rochester, New York 14607

585-262-2820

585-563-2487 (Fax)

CLIENT INFORMATION FORM

Name _____ DOB _____

Address: _____

Home Phone _____ Work Phone _____ Cell _____

Referred by: _____

Person to contact in case of emergency: _____

Relationship: _____ Phone _____

Employer: _____ Position: _____

#years with employer: _____

Insurance: _____ Contract# _____

Subscriber: _____ Subscriber's employer: _____

Marital Status: _____ Spouse/partner _____

Number of times married _____

Children:

Name: _____ Age: _____

Household Members: _____ Age: _____ Relationship: _____

Parents:

Were your parents divorced? Yes No

Your age at the time of divorce: _____

Siblings:

EDUCATION

Highest grade completed:

High School _____ College _____ Vocational Training _____ Grad school _____

Any history of learning disabilities or Attention Deficit Disorder? Yes No

What concern(s) bring you to counseling at this time?

What changes do you want to see as a result of counseling?

Signature: _____ Date: _____