Suzanne D. Heffner Counseling, LLC
Licensed Clinical Marriage & Family Therapist

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Client Information Form

Name **Date**

Address:
Street

City State Zip

Home phone ( ) Work phone ( ) Cell phone ( )

Can a message be left at the above phone numbers? **(Please circle Yes or No)**

Home -- yes no Work -- yes no Cell --- yes no

Social Security # ---- ---- Date of Birth

Spouse's name

If client is under 18, name of parent(s)

Employer Occupation

Person to contact in case of an emergency

Name Relationship

Home phone ( ) Work phone ( ) Cell phone ( )

Referred by

Name Relationship (e.g. friend, doctor, employer)

May I thank this person/organization for referring you to me? ☐ Yes ☐ No

What difficulties have brought you here today?

What actions, if any, have you taken toward finding a solution?

In the past, have you received counseling and/or been hospitalized for psychiatric purposes? When?

Please list current physical symptoms/medical illnesses

Please list current medications and dosage

What do you hope to gain from counseling?