

GRANBERRY COUNSELING CENTERS

Client Name _____ Birth date _____ Age _____
 Responsible Party _____ Birth date _____ Relationship to Client _____
 Client Mailing Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____
 Place of Employment/School _____ Occupation _____
 Religious preference _____ Church you attend _____
 Marital Status: Single _____ Married _____(yrs) Divorced _____(yrs) Widowed _____(yrs) Separated _____(yrs)
 Spouse/Responsible Party Spouse _____ Birth date _____ Age _____
 Place of Employment _____ Work Phone (____) _____

Responsible party contact information if different from that of the client:

Mailing Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

List all others living in the client's home:

Name	Birth date & Age	Relationship (ex. – son, daughter)	School/Place of Employment

Check all the items that describe the concerns that bring you to counseling:

Hopelessness Grief School Fear Violence
 Guilt Pre-Marital Loneliness Work Anger
 Parenting Anxiety Sexual Issues Depression Religious Issues
 Marital Issues other (please specify) _____

List current medical problems/medications of any family member:

Have you ever received psychiatric or psychological help or counseling of any kind before? Yes No

How did you hear about Granberry Counseling Centers? _____

Additional information requested: (please check all that apply)

Last Grade Completed _____ High School Diploma/GED _____ College Degree _____ Graduate Degree _____

below \$30,000 \$30,001 to \$40,000 \$40,001 to \$50,000
 \$50,001 to \$60,000 \$60,001 and up

(see reverse side for further information)

Counselor Use Only:

Date: _____ I/C/F/CH _____ M/F _____ B/W/O _____ Case # _____