Jennifer Ozment Caldwell

Client Information Form

Please read and complete all information requested. Date:_______________

Name: ____

Address: ____

City, State and Zip: ____

Home Phone: _________________________________ Work Phone: ______________________________

Cell Phone: ___________________________________ Email: ____________________________________

Can we contact you and leave messages at: Home?___ Work? ____ Cell? ____ Email? ________

Birth Date: _______________ Male ____ Female ____

Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Ethnicity: African-American Caucasian Hispanic Indian

Multi-racial Native American Other (please indicate): __________________

Who referred you? ____

Name of Church/Ad judicatory: ____

Denomination: ____

Occupation and Employer: ____

Student: Full-time ____ Part-time ____

Please state briefly your reason for seeking counseling:

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Other information Jennifer Ozment Caldwell might find helpful:

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Self-Description Checklist (Please check all that apply):

__ Angry	__ Hopeless	__ fatigued	__ confused
__ energetic	__ suicidal	__ resentful	__ irritated
__ ambitious	__ dangerous	__ unhappy	__ depressed
__ happy	__ lonely	__ violent	__ sleep problems
__ inadequate	__ marital conflict	__ parent conflict	__ work stress
__ anxious	__ isolated	__ fearful	__ bereaved
__ guilty	__ ashamed	__ cheerful	__ optimistic
__ distrustful	__ apathetic	__ hurt	__ numb
__ abused	__ loss of appetite	__ worried	__ panic
__ hopeful	__ jealous	__ indifferent	__ poor sex drive
__ faith issues	__ overeating	__ drug use/abuse	__ alcohol abuse
__ fretful	__ unwelcome thoughts		

Are you currently taking any medications, prescriptions or over the counter?: ____ Yes ____No

If yes, specify type, dose and reason for taking: ____

____

If prescription, who prescribed them? ____

Please fill in the following information for any 3rd party that will be responsible for client payments (This section is required for clients who are minors)

First Name: __________________________ Last Name: ___________________________________

Address: ____

City, State and Zip: ____

Emergency Contact: ____

Medical Concerns: ____