



222 Southside Avenue · Mooresville, NC 28115
704-658-0238 · 704-658-0896 FAX
www.CCofMooresville.com

CLIENT INFORMATION FORM

Name: _____ Date of Birth: _____

First Middle Last

Address _____ City _____ State ____ Zip _____

Social Security #: _____ - _____ - _____ Home phone number: _____

Work number: _____ Cell number: _____

Email address: _____

Relationship Status: ___ Single ___ Committed ___ Engaged ___ Married ___ Separated ___ Divorced ___ Widowed

If married, years married _____ Spouse's Name: _____

Names/Ages of Children: _____

If separated, divorced, or widowed, years/months _____ separated _____ divorced _____ widowed

If single, do you have a significant relationship? ___ Yes ___ No Significance _____ How long? _____
(boyfriend/girlfriend, committed partner, etc.)

Names/Ages of Siblings _____

Recent deaths of family/friends (Relation/dates) _____

Education

High School Diploma? ___ Yes ___ No If no, highest grade completed (circle one) 1 2 3 4 5 6 7 8 9 10 11

College 1 2 3 4 Name of College _____ Degree(s) _____

Graduate School 1 2 3 4 Name of College _____ Area of Study _____

Business/Technical School _____

Occupational Information

Employer _____ Length of Employment _____

Type of work you do _____

Physical and Emotional Information

List current illness(es) or symptoms _____

List any major surgeries, serious crises, losses, or handicaps (with dates) _____

Last medical exam _____ Reason _____



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Continued (Client Information Form)

Name and Address of Physician _____

Current Medications _____

Have you ever received psychotherapy, counseling, or other treatment for personal, marital, or family problems?
Yes No Dates _____ Name of Professional (Dr., agency, pastor, etc.) _____

Have you or any member of your family ever received or considered seeking help for drug or alcohol
dependency? Yes. No. Date _____ Name of Professional/Agency _____

Substances Used _____

Who referred you to Christian Counselors of Mooresville? _____

Person Responsible for Payment _____

Type of Counseling: Individual Family Group

Racial/Ethnic Identity: African-American Asian Caucasian Hispanic Native American Other _____

Religious Preference _____ Local Congregation _____

Emergency Contact Person _____ Phone #: _____

IMPORTANT QUESTIONS FOR YOU AND YOUR COUNSELOR

Please describe your reason(s) for seeking help _____

Three horizontal lines for describing reasons for seeking help.

What would you like to have happen as a result of counseling? _____

Three horizontal lines for describing desired outcomes from counseling.

Date of initial visit: _____

FOR OFFICE USE ONLY

Counselor: _____ Diagnosis: _____

A-U-F-P-B-C: _____ Length of Visit: 1/2 Hr. Hr. Hr. & 1/2 2 Hrs.