

Laura Young, LCSW Counseling Services, P.C.
Laura L. Young, LCSW-R, CGP
315 W. 57th St. Suite 310
New York, NY 10019
Tel: 212.581.9466

CLIENT INFORMATION SHEET

NAME _____ HOME PHONE NO. _____
CELL NO. _____ WORK NO. _____ (circle best way(s) to contact you)

E-MAIL ADDRESS: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ CITY/STATE/COUNTRY OF BIRTH _____

STATUS: SINGLE _____ MARRIED _____ SEPARATED _____ DOMESTIC PARTNER _____

ENGAGED _____ WIDOWED _____ DIVORCED _____

NAME OF PARTNER OR SPOUSE IF MARRIED _____

HOW LONG MARRIED/PARTNERED _____ WERE YOU MARRIED BEFORE? _____

IF YES, HOW LONG: _____ 2ND/3RD MARRIAGE? IF YES HOW LONG: _____

CHILDREN? NO. OF GIRLS: _____ AGES: _____ / _____ / _____ NO. OF BOYS _____ AGES: _____ / _____ / _____

EDUCATION: HIGHEST GRADE OR DEGREE _____

LIVE WITH: SELF _____ PARTNER/SPOUSE _____ CHILDREN _____ ROOMMATE _____ OTHER _____

MOTHER: LIVING ___ DECEASED, WHEN _____ FATHER: LIVING ___ DECEASED, WHEN _____

NO. OF BROTHERS: ___ ANY DECEASED: _____ NO. OF SISTERS: ___ ANY DECEASED: _____

WHAT NUMBER IN RANK ARE YOU? _____

TYPE OF WORK YOU ARE DOING NOW: _____

NAME AND ADDRESS OF EMPLOYER: _____ TELE. # _____

LENGTH OF EMPLOYMENT AT THIS POSITION: _____

PAST EMPLOYMENTS: _____

HAVE YOU HAD ANY ILLNESSES? _____

HOSPITALIZATIONS? _____ IF YES, WHY AND HOW LONG: _____

MEDICATIONS: _____ REASONS FOR MEDICATION: _____

ANY PREVIOUS COUNSELING: ___ YES ___ NO IF YES, HOW LONG: _____

YES, WHAT TYPE AND WITH WHOM: _____

WHEN DID YOU DISCONTINUE? _____ WHY? _____

Why are you seeking therapy? (Please be as specific as possible) _____

How (if internet-what site/sites) or by whom were you referred? _____