LIBERTY
COUNSELLING

Client Information Form

Client's Name:_____ Today's Date:_____

Nationality:_____Date of Birth:_____ Sex: (Circle one) F M

Address: _____

City:_____ Postcode: _____Mobile:_____

Occupation: _____ Email: _____

Marital Status: _____ Spouse's (Partner's) Name: _____

Children: (Names and ages) Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Religious Denomination (If any): _____

Are you currently seeing another therapist? (Circle one) Yes No

If yes, then therapist's name: _____

Are you currently taking medication for a psychiatric problem? (Circle one) Yes No

If yes, please list the name of each medication:

_____

_____

Please circle each problem below for which you would like help:

Anxiety Depression Self-esteem Worry Control Self-criticism Anger

Perfectionism Guilt Shame Low Energy Procrastination Hopelessness

Assertion Loneliness Regrets Suicidality Shyness Inactivity

Other (Please specify):

_____

_____

_____

_____

_____