Fountain City Counseling
133 First Street
Prattville, Alabama
Thealangleymft.com
Client Demographic Sheet

We request this information so that we may know about you and be better able to serve you; however, if there are any questions that you do not wish to answer, you are not obligated to do so.

GENERAL INFORMATION (Primary Client) Date:________________

Name:______________________________________ Sex:__________ Ethnicity:_______________

Date of Birth:_______________ Age:________

Address:______________________________________City______________State____Zip_________

Home Phone:________________________Business Phone______________________Ext:________

Cell Phone ______________________________ Email __________________________________

Secondary Client (Must be the LEGAL GUARDIAN if Primary Client is a Minor)

Relationship to Client ______________________

Name:______________________________________ Sex:__________ Ethnicity:______ DOB_________

Address:____City_____________State____Zip_________

Home Phone:_________________________ Business Phone___________________ Ext: _________

Cell Phone ______________________________ Email __________________________________

EMPLOYMENT

Occupation:_____________________________Employed by:______________________________
No. of dependents:_____________________ Total household income:_____________________

EDUCATION

Years of formal education completed: 1 2 3 4 5 6 7 8 9 10 11 12 (Circle highest year)
College 1 2 3 4 Degree obtained:_______________
Graduate School Degree obtained:_______________

RELIGION

Denomination:___________________Church/Temple/Synagogue:__________________________
Pastor/Priest/Rabbi: ____

☐ I would like my spirituality addressed in my therapy (if not skip to the next section)

Is there anything you would like to share about your childhood or adult spiritual history?
____

Are there any conflicts with your family or origin or current family about your spirituality?
____

MARITAL STATUS

Single ☐ Engaged ☐ Living together ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐

Number of times married:__________________ Date(s) of death of mate(s):_______________
Date(s) of marriage(s):________________________ Date(s) of divorce(s):____________________

Other Adults in the Household:

Name:____Age:________
Address____Phone #_______________________
Occupation:______________________________Employed by:______________________________

CHILDREN

Name	Age	Sex	Descriptive Words

FAMILY HISTORY

	Mother	Father
Living (if yes, age):		
Education/Occupation:		
Number of times married:		
Descriptive words:		

Emotionally closer to Mother ☐ or Father ☐

If parents are separated ☐, divorced☐,or deceased☐,what was your age at that event?________ What is/was your greatest difficulty with your parents?______________________
____
____

In your family, you are ______________in birth order of _________children.

PROBLEM OR STRESS INFORMATION

What are you experiencing and/or what has happened to cause you to seek counseling?
____
____
Have you had previous counseling/psychotherapy? Yes ☐ No ☐ If yes, date(s)_______________
With whom: ____
Issues addressed:____

What do you wish to change in your life?____
____

How do you expect Fountain City Counseling to assist you in making that/those change(s)? ____

GENERAL HEALTH

How would you rate your general physical health? Excellent☐ Good☐ Fair☐ Poor ☐
Any medical conditions? Yes ☐ or No ☐ If yes, name _________________________________
Are you under the care of a physician? Yes ☐ or No ☐
If yes, physician's name____
When was your last physical examination? ____
Please list medication(s) taken regularly (Continue in the back of the page if necessary) __________
____
____
Do you exercise Yes ☐ No ☐ How often? ____
List past major emotional and/or physical difficulties you have experienced [please also give date(s)]
____
____
____
Do you drink alcohol? Yes ☐ No ☐ How often? ____________________________________
How much when you do drink? ____

Please initial where required and if it applies to you.

_______ I give permission to contact _____________________________ in case of emergency.
Relationship _____________________________
Home: ________________ Cell:__________________ Work: _________________

_______ I give permission for Fountain City Counseling to thank the referring person.

_______ I received and reviewed a copy of Fountain City Counseling's “Privacy Practices”

_______ I received and reviewed a copy of Fountain City Counseling's “Informed Consent”

_______ I agree that the per session fee is: _____________________

With your signature below, you are stating that you understand all policies, agree to abide by all conditions stated in the Informed Consent and Privacy Practices, and agree to all the above statements you initialed.

_______________________________ ____________________
Client’s Signature Date

_______________________________ _____________________
Client’s Signature Date

_______________________________ ______________________
Signature of financially responsible Party Date
(If client is a minor or not financially responsible)

_______________________________ ______________________
Therapist’s Signature Date

Revised 2015