Client Information Sheet
Amy R. Ellis, MFT

Name:_____ Date of Birth:_____ Gender: M F
Occupation:_____ Employer:_____ Religion (Optional):_____
Address:_____(city)_____(zip)_____
Home Phone:_____ Cell Phone:_____ Other:_____ (*mark preferred)

Partner/Spouse Name_____Date of Birth:_____ Gender: M F
Occupation:_____ Employer:_____ Religion (Optional):_____
Address (if different):_____
Home Phone:_____ Cell Phone:_____ Other:_____ (mark preferred)

Individual/ Family combined annual income (circle one)
$10-19,999 20-35,999 36-49,999 50-75,999 76-99,999 100-125,000 125,000+

Number of marriages (including current) for You_____ Your partner_____ Years in current relationship____

Please list below all children from this or previous marriages/relationships; whether or not they live with you:
Name(s) Age Gender
_____
_____
_____
_____

List Current Medications:_____

Medical Concerns:_____

Name of Physician:_____Phone:_____ Date of last physical:_____
Will you sign release:
Current Service Providers:_____ yes no
Any Past Service Providers Will you sign release:
(Therapists,psychiatrist, etc.):_____ yes no

Indicate who (using initials) has any of the following symptoms: ___Thoughts of Suicide ___Suicide attempts

____ Work Problems _____Depression ____Anxiety ____ Trauma ____Anorexia/Bulemia

____Harm yourself ____Sexual Problems ____School Problems ____ Sexual/Physical/Emotional abuse

____Drinking problem ____Legal problems _____Physical Aggression _____Parenting / Child Concern(s)
(pushing, slapping, etc.)

Has anyone being seen ever abused drugs? Yes No If yes who and, which drugs:_____

What brought you in today?_____
_____

What are your goals for therapy?_____
_____

How did you hear about me?_____ Is it okay to call at above numbers? Yes No

Signature of person filling out form:_____ Date:_____