John D. Michael, Ph.D., L.P.C.
9332 E. Raintree Dr., #160
Scottsdale, AZ 85260
(602) 312-7214

Client Information Form

To help me with our first session, please fill out the following information as completely as possible and bring the completed form with you to your first counseling session.

Date: _____

Name: _____ Age:_____ **Date of Birth**:_____
First Middle Initial Last

If married, spouse's name: _____ Age: _____ **Date of Birth:**_____

Number of Years Married: _____ Anniversary: _____

Address: _____

Phone: (H) _____ (W) _____ (Cell) _____

E-mail address:_____

If divorced, ex-spouse's name (s): _____ Date of Divorce: _____

_____ Date of Divorce: _____

Children:

Name: _____ Age: _____

Name:_____ Age: _____

Name: _____ Age: _____

Name:_____ Age: _____

Name: _____ Age: _____

Employment: Job Title/Work Type _____

_____

Place: _____

Family Physician Name: _____

Are you taking any prescription medication at this time? Yes ____ No ____

If yes, what type and for what purpose _____

_____

Who referred you for counseling? _____