# LARRY ROACH LMHC
## Professional Counseling

**Client Information Form**
For Confidential Use Only

Your Name: _____ Date: _____

Address: Street _____ City _____ State _____ Zip _____

Home Phone: _____ Cell: _____ Other Phone: _____

Email Address: _____ Your Date of Birth: _____

Name of spouse (if app) _____ Spouse's Date of Birth: _____

Children: Name: _____ Age: _____ Name: _____ Age _____
Name: _____ Age: _____ Name: _____ Age _____

In case of emergency contact: _____ Relationship _____ Phone _____

Religious Preference: _____ Church: _____

Name of person or organization who referred you: _____

Have you received previous counseling? By whom? When? _____

_____

Briefly describe your major reasons for coming to counseling and what you hope to accomplish:

_____

_____

**Please complete the following information if applicable:**

Has anyone in your family been treated for a mental disorder? _____ Who? _____

Physician's Name _____ City _____ Date of last physical exam: _____

Psychiatrist's Name _____ City _____ Date of last visit: _____

Significant *past* medical conditions and years _____

_____

*Current* medical conditions (include any known allergies or dietary concerns) _____

_____

_____

Medications you are *currently* taking and for what reason _____

_____

**Thank you for the information. I look forward to helping you achieve your personal goals.**