ECFA COUNSELING CENTERS
CLIENT APPLICATION

This form must be completed by each client 14 years and older.
If the client is younger than 14, the parent or guardian should complete.

Date: _____

Client Name: _____ Birth Date: _____ Age: _____

Parent/Guardian Name: _____
(circle one)

Address: _____
street city state zip

Home Phone: (____) Work Phone: (____) e-mail: _____

Racial/Cultural/Ethnic Background: _____

Others involved in counseling with you:

Name: _____ Birth Date: _____ Age: _____ Relationship: _____

Name: _____ Birth Date: _____ Age: _____ Relationship: _____

Name: _____ Birth Date: _____ Age: _____ Relationship: _____

Others immediate family members NOT involved in counseling with you:

Name: _____ Birth Date: _____ Age: _____ Relationship: _____

Name: _____ Birth Date: _____ Age: _____ Relationship: _____

Name: _____ Birth Date: _____ Age: _____ Relationship: _____

Marital Status:

Single_____ Married _____ Co-habitating_____ Separated_____ Widowed _____
Date Date Date Date

Previous marriage/divorce dates: _____

Emergency Contact Information:

Name: _____ Phone: _____ Relationship: _____

Specify any other CURRENT mental health treatment (e.g. psychiatrist, substance abuse):

Name and location of this professional: _____

Specify any prescribed medications and the purpose: _____

Name and location of physician prescribing medications: _____

Specify date range and purpose for previous counseling: _____

Name and location of previous counselor: _____

Specify any medical conditions we should be aware of: _____

Name and location of physician treating condition(s): _____