Cory Wilkin, MS, LMFT
Licensed Marriage and Family Therapist
License#: MFC51433
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Client Background Information Form

Personal Information

Client Name:

Date of Birth (age):

Sex: ☐ Male ☐ Female

Today's Date:

Home Address:
Street:
City:
State: Zip Code:

Mailing Address (if different from home address):
Street:
City:
State: Zip Code:
May we send confidential information to this address? ☐ Yes ☐ No

Primary Phone: ( )
May we call you at this number? ☐ Yes ☐ No
May we leave confidential messages at this number? ☐ Yes ☐ No
May we text message you at this number? ☐ Yes ☐ No

Email Address:
May we send email to this address? ☐ Yes ☐ No
May we email confidential information to this address? ☐ Yes ☐ No

Present Employer/School:

How long have you been with this employer?

Occupation/Major:

Highest Level of Education:
☐ High School
☐ Vocational Training
☐ Some College
☐ College Graduate
☐ Some Graduate School
☐ Graduate School

List present or previous health problems:

Emergency Contact:
Name:
Phone: ( )

List any medications you are taking (Please include dosages):

Primary Physician:

Groups, clubs, or activities you participate in:

Relationship/Marital Status (Check all that apply):
☐ Single ☐ Separated ☐ Married
☐ Cohabitating ☐ Widowed ☐ Divorced

Length of current marriage or cohabitation (if applicable):

Length of separation or divorce(s) (if applicable):

Please briefly describe the concern that has brought you to counseling at this time and/or what you wish to accomplish through therapy at this time:

Previous Counseling Information

Please list the name of any other professional counselors or agencies you have utilized before coming here	Date(s) of Service	Brief description of treatment (i.e. martial counseling, depression treatment, etc.)

Spouse Information (if applicable)

Spouse's Name:

Spouse's Age:

Sex:
 Male Female

Spouse's Address (if different than above):

Street:

City:

State: Zip Code:

Spouse's Phone: ( )

Phone type: Home Cell Work

Is it okay to contact your spouse? Yes No

Spouse's Present Employer:

How long has your spouse been with this employer?

Spouse's Occupation:

Spouse's highest level of education:
 High School
 Vocational Training
 Some College
 College Graduate
 Some Graduate School
 Graduate School

Spouse's present or previous health problems:

Spouse's medications (Please include dosages):

Child Information (if applicable)

Name	Age	Living with you?	Is child from a previous relationship?	Year in School (e.g., 1st, 3rd, 11th)	List any medications and/or current personal problems (if applicable)

Please list any other persons living at home and/or anyone relevant to treatment

Name	Age	Relationship	List any medications and/or current personal problems (if applicable)

Financial Party Information

Name:

Relationship to Client:

Mailing Address (if different from above):

Street:

City:

State: Zip Code:

May we have permission to send confidential info to this address? Yes No

Phone (If different from above): ( )

Phone type: Home Cell Work
May we call this number? Yes No
May we leave confidential messages at this number? Yes No
May we send text messages to this number? Yes No

Email Address (If different from above):

May we send email to this address? Yes No
May we email confidential info to this address? Yes No