

Cluff Counseling PLLC

www.cluffcounseling.com | Melissa@cluffcounseling.com

Counseling Services Application

Personal Information

First name	Middle initial	Last name			Today's date:	
Street address	City	State	Zip	Birthdate:	Cell Phone:	
Email Address	Sex: <input type="radio"/> Male <input type="radio"/> Female			Employer name:		

List present or previous health problems:

List any medications you are currently taking and their purpose (ex: Wellbutrin for depression):

Spouse or Parent Information if client is under 18

First name	Middle initial	Last name			Marriage date:	
Street address	City	State	Zip	Birthdate:	Cell Phone:	
Email Address	Sex: <input type="radio"/> Male <input type="radio"/> Female			Employer name:		

List present or previous health problems:

List any medications you are currently taking and their purpose:

Children's Information

Instructions: List all children

Name	Age	Lives with you?	Name	Age	Lives with you?

Other Information (PLEASE COMPLETE THIS SECTION)

What do you hope to accomplish by seeking therapy services at this time?

Have you received counseling services in the past? **YES** **NO**

If yes, please share when and for what issues?

Signature (Client 1)

Signature (Partner or parent, if client 1 is under 18)

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