CLIENT INFORMATION

For Confidential Use Only

Name ____ **Date**_____________________

Address____

Street Number and Name City State Zip Code

Township: ___________________________________ **Is This Address in an Unincorporated Area?** ☐ **Yes** ☐**No**

Birth Date: _____/_____/________ **Gender:** ☐**Female** ☐**Male** ☐ __________________

Preferred Phone: _________________________________ ☐ **Home** ☐ **Cell** ☐ **Work** ☐Check if OK to leave message

Alternative Phone: _______________________________ ☐ **Home** ☐**Cell** ☐**Work** ☐ Check if OK to leave message

Marital Status: ☐ **Single, Never Married** ☐ **Married/Partnered/Cohabiting** ☐ **Divorced**
☐ **Separated** ☐ **Widowed**

Race/Ethnicity: ☐ **African American or Black** ☐**American Indian or Alaska Native** ☐**Asian**
☐ **Hispanic** ☐ **Native Hawaiian/Other Pacific Islander** ☐ **White/Non-Hispanic**

Language(s) Spoken in the Home: ☐ **English** ☐**Spanish** ☐**Polish** ☐**Other** ____________________________

Highest Level of Education:

Adult Client: ☐**High School** ☐**Trade School** ☐**Jr. College** ☐**College** ☐**Graduate School**

OR

Parent/Guardian #1: ☐**High School** ☐**Trade School** ☐**Jr. College** ☐**College** ☐**Graduate School**

Parent/Guardian #2: ☐**High School** ☐**Trade School** ☐**Jr. College** ☐**College** ☐**Graduate School**

Work: ☐ **Full-Time** ☐**Part-Time** ☐**Student** ☐**Unemployed** ☐**Disabled** ☐**Retired**

Hospital(s) at which you receive medical care, when necessary (select all that apply):
☐ **Evanston** ☐ **Glenbrook** ☐ **Highland Park** ☐ **Skokie** ☐**Other:** _________________________

IF CLIENT IS A MINOR: Person responsible for payment ____

Billing Address, City, State, Zip Code ____

Gross Annual Family Income: $_______________________ **/year** ◆ **Number Dependent on Income:** ___________

Family and Household Members (includes housemates, spouse, partner, children; continue on back if needed).

Name	Birth date / Age	Sex (F/M)	Relationship	Living with you?
________________________	____________	_____	__________________	☐Yes ☐ No
________________________	____________	_____	__________________	☐Yes ☐ No
________________________	____________	_____	__________________	☐Yes ☐ No
________________________	____________	_____	__________________	☐Yes ☐ No
________________________	____________	_____	__________________	☐Yes ☐ No

Have you had previous counseling/therapy? ☐ *Yes* ☐ *No If yes:* ☐ *FSC* ☐ *Other*

Who referred you to Family Service Center?

☐ Agency / Clinic ☐ Clergy ☐ EAP ☐ Friends ☐ Insurance ☐ Legal

☐ Medical ☐ Police ☐ Publicity ☐ Schools ☐ Self ☐ Other ______________