



Date: _____ Agency: _____

Counselor/Clinician: _____

Number of sessions: _____ Duration: _____

CLIENT INFORMATION

Client: _____

Date of Birth: _____ Age: _____

Gender: _____ Marital Status: _____

Highest level of Education: _____

Employed: Yes/No

If "Yes" name employer: _____

Tenure of employment: _____

Medical

History: _____

Medications: _____

History of any substance abuse or mental illness (include family history):

Do you belong to any social/professional clubs or organizations?

Pleasure and relaxation activities: _____

Presenting Problems: _____

Results of Mental Status Exam: _____

Client's Strengths & Weaknesses: _____

Clinician's/Counselor's observations & comments:

Treatment undertaken: _____

In your professional opinion is this client suitable to enter into the Masters of Arts in
Counseling program?

Recommendations: _____

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Signature of Counselor/Clinician.