RASMUSSEN
COUNSELING

Information Sheet

First Name **Middle Initial** **Last Name**

Telephone Number

Home or Apartment Street Address **City** **State** **Zip Code**

DOB: **Gender:** ☐ Male ☐ Female

Martital Status ☐ Never Married ☐ Married ☐ Living as Married ☐ Separated ☐ Divorced ☐ Widowed

Employment Status:

☐ Working full time (more than 35 hours per week)
☐ Working part time (less than 35 hours per week)
☐ Unemployed, seeking work in past 30 days
☐ Unemployed, not seeking work
☐ Full time member of the Armed Services
☐ Retired
☐ Homemaker
☐ Student/Child
☐ Disabled

Employer: Address: Phone Number:

Occupation:

Primary Care Physician: Phone:

Primary Psychiatrist: Phone:

Next of Kin (Relationship): Phone:

Next of Kin Mailing Address:(optional):

Emergency Contact: Phone:

Allergies:(Medications or Food)

Medications:Psychotropic or Medical:

CLINICAL INFORMATION

To be completed by Client or Guardian: **Presenting Problems:** (Chief complaint, precipitant, stressors, symptoms and behaviors, why Tx now)

Client Signature:_____ Date:_____

Guardian Signature:_____ Date:_____