Sally Erickson, M.A., CAP
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Individual Client Information & History

Name: ______________________________ Date: ____________

Address: ______________________________________

City: ______________________ State: ________ Zip: ______

Referred by: ________________________

Please indicate your preferred contact phone or email to reach you.

Phone: Cell____________ Home:____________ Office:____________

Email: ______________________ May I text your cell phone? Yes/No

Date of Birth: ______________ Gender: ________ Race/Ethnicity ______

Education: __________________ Occupation: ________________

Marital Status: ______________

Primary Care Physician: ______________________ Ph. #: __________

Medications: ______________________________________

Please briefly describe the issues that brought you to counseling:

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What is your primary goal for counseling? ______________________

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