Family
Education and
Counseling
Center Inc.

Individual Counseling
Marriage & Family
Counseling
Anger Management
Children & Adolescents

Client Information – Confidential

1700 Burleigh Street ◆ Yankton, SD 57078 ◆605-260-928

Please fill out fully to the best of your knowledge.

Client: ____
Last Name First Name Middle Initial

Address: ____
Street/ PO Box City State Zip Code

Gender: __________ Age________ Date of Birth___/____/_____

Race: (Please Circle) Asian African American Caucasian Hispanic
Native American Other____________________

Telephone ______________________Cell/Home/Work ______________________ Cell/Home/Work

Occupation____________________ Employer_______________________

Marital Status: ___Married ___Divorced ___Widowed ___Separated ___Living Together
Length of relationship_______ ___Single

Spouse/Partner____
Last Name First Name Middle Initial

Address: ____
(If different) Street/ PO Box City State Zip Code

Gender: __________ Age________ Date of Birth___/____/_____

Race: (Please Circle) Asian African American Caucasian Hispanic
Native American Other_____________________

Telephone ______________________Cell/Home/Work ______________________ Cell/Home/Work

Occupation____________________ Employer_______________________

Children:
Name Age Gender

____
____
____
____

Spouse/Partner's Children:
Name Age Gender

____
____
____
____

Custody arrangements____

Others living in the home:____

Major Medical Issues or Surgeries: ____

Medications:____

____

Current Physical Symptoms/Ailments______________________________________

____

Physician:_________________________ Location:___________________________

Check all of the following that apply:

____ Stress	_____Grieving a Loss	______Anxiety/Worry
_____Behavior Problem	_____Parent/Child Relationship	______Depression
_____Phobia	_____Alcohol or Drug Use	______Violence
_____Fear	_____Anger	______Pain
_____ Marital/Relationship	_____Abuse (physical, sexual, emotional)	______Mood Swings
______Sleep Changes	_____Health Problems	______Appetite Issues
______Self Mutilation	_____Difficulty Concentrating	______Legal Issues

_____Others____

Who supports you personally?____

____

Is spirituality/religion a part of your life? Yes No Church:____________________

Counseling Goals____

Referred Here By:____

Previous Counseling Experience:____________________________________

Counselor:____

Insurance: If you have your card may we photocopy it for billing purposes?

_____Blue Cross/Blue Shield ____Avera Health Plan ______Sanford Health Plan
_____DakotaCare ______Medicaid ______Other______________

Name on Card:____

Account Number:____

Insurance Source (Employer, Self)______________________________

Insurance Company Address: _________________________________

Insurance Company Phone Number_____________________________

Other information:_______________________________________

Signature:__________________________ Date________________