Family
Education and
Counseling
Center Inc.

Individual Counseling
Marriage & Family
Counseling
Anger Management
Children and Adolescents

1700 Burleigh Street • Yankton, SD 57078 • 605-260-9284

Client Information – Couples- Confidential

Please fill out fully to the best of your knowledge.

____
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____________________

Signature:________________________________ Date____________________