

**Sharon Eiler, MA, LMFT**

**Client Information**

Name (first, middle, last): \_\_\_\_\_ DoB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Text? \_\_\_\_\_

Email address: \_\_\_\_\_

May I leave a message with my name and app't information at these numbers? \_\_\_\_\_

Who referred you to this practice? \_\_\_\_\_

May I thank them, without using your name? \_\_\_\_\_

Female     Male     Transgender     Other \_\_\_\_\_

Marital Status:  Single     Married     Partnership  
 Divorced     Separated     Widowed

Please list Family/Household Members:

| Name | Age | Relationship to Client | In Same Home? |
|------|-----|------------------------|---------------|
|      |     |                        |               |
|      |     |                        |               |
|      |     |                        |               |
|      |     |                        |               |
|      |     |                        |               |
|      |     |                        |               |
|      |     |                        |               |
|      |     |                        |               |

Household Gross Annual Income: \_\_\_\_\_

Please list other important people involved in your life, and their relationship to you: \_\_\_\_\_

Spiritual/Religious/Cultural Identification: \_\_\_\_\_

Primary language? \_\_\_\_\_ Are you an immigrant or refugee? \_\_\_\_\_ 1<sup>st</sup> Generation? \_\_\_\_\_

Highest level of education: \_\_\_\_\_