

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? |
|------|-----|------------------------|---------------|
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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? _____ 1st Generation? _____

Highest level of education: _____