KATHLEEN JOSEPH
& ASSOCIATES LLC.

CLIENT INFORMATION FORM
FOR UNIVERSITY OF FLORIDA STUDENTS-ATHLETES ONLY

TODAY'S DATE: _____

TEAM (if applicable): _____

NAME (LAST, FIRST, MI):_____

DATE OF BIRTH:_____ AGE: _____ GENDER IDENTITY: _____

ETHNICITY/RACE: _____ SEXUAL ORIENTATION: _____

RELIGIOUS/SPIRITUAL AFFILIATION:_____ HOW OFTEN DO YOU ATTEND? _____

ADDRESS: _____
STREET (APT #) CITY STATE ZIP CODE

TELEPHONE NUMBER: _____ OK TO LEAVE MESSAGE? _____

EMAIL ADDRESS:_____

PARENT(S) NAMES: _____

STEP-PARENT NAME: _____

OTHER SIGNIFICANT FAMILY MEMBERS:

FIRST NAME	AGE	RELATIONSHIP TO CLIENT

EMERGENCY CONTACT (FOR MEDICAL EMERGENCY ONLY)

NAME, PHONE: _____ RELATIONSHIP? _____

DO I HAVE PERMISSION TO CONTACT THIS PERSON IN EVENT OF EMERGENCY? ◯Y / N◯ INITIAL_____

352.246.3693 | info@KJandA.org | www.KJandA.org
1225 NW 10th Ave, Gainesville, FL 32601

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& ASSOCIATES LLC.

PLEASE GIVE A BRIEF SUMMARY OF THE REASONS THAT YOU ARE SEEKING COUNSELING: _____

_____

_____

WHAT ARE THE MOST IMPORTANT QUALITIES YOU LOOK FOR IN A COUNSELOR?_____

_____

_____

PAST EXPERIENCES WITH COUNSELING OR MENTAL HEALTH TREATMENT:

NAME: _____ DATE: _____ POSITIVE? ○Y / N○

HISTORY OF SUBSTANCE ABUSE? ○Y / N○

IF YES, GIVE A BRIEF DESCRIPTION:_____

_____

_____

PAST PSYCHIATRIC/THERAPY TREATMENT INCLUDING HOSPITALIZATIONS: ○Y / N○

IF YES, PLEASE GIVE A BRIEF DESCRIPTION: _____

_____

_____

MEDICATION(S) _____

_____

PSYCHIATRIST:

_____ _____

NAME CONTACT INFORMATION (ADDRESS, PHONE NUMBER)

GENERAL PRACTITIONER:

_____ _____

NAME CONTACT INFORMATION (ADDRESS, PHONE NUMBER)

HAVE YOU EVER BEEN SUICIDAL? ○Y / N◉

IF YES, WHEN AND BRIEFLY DESCRIBE: _____

_____

CURRENTLY SUICIDAL? ○Y / N○

DESCRIBE FEELINGS/SITUATION: _____

Thank you! We look forward to serving you!

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