

Personal Best Consulting Client Information

* Please note that all information will be treated as private and confidential*

1. Date: _____

2. Name: _____ 3. DOB: _____ 4. Gender: M or F

5. Address: _____

6. Email: _____

7. Phone (Home): _____

(Cell): _____

(Workplace): _____

8. Height: _____ 9. Weight: _____ 10. Race/Ethnicity: _____

11. Reason for visit: _____

12. How long has this problem persisted? _____

13. Were you referred for counseling? _____

14. If yes, by whom? _____

15. If you weren't referred, how did you find Personal Best Consulting?

16. Have you previously received counseling services? Y or N

17. If yes, for what issue(s) and for how long?

18. Name of your primary care physician (or team physician):

19. Please list any health issues (past or present) that affect your daily living:

20. Are you currently taking medication? If yes, please list reason:

21. What do you hope to accomplish in our counseling work together?
