

**SHIELD-BEARER COUNSELING CENTERS**  
**12345 Jones Rd. Suite 285**  
**Houston, TX 77070**

**Client Information Sheet**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Spouse: \_\_\_\_\_

Age and Date of Birth: \_\_\_\_\_ Spouse's: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone: (h) \_\_\_\_\_ Leave a message? ( )Yes ( )No

(c) \_\_\_\_\_ Leave a message? ( )Yes ( )No

Name(s) and age(s) of child(ren): \_\_\_\_\_

\_\_\_\_\_

Name of Parent(s) if minor: \_\_\_\_\_

Referred by: \_\_\_\_\_

**HEALTH HISTORY**

Have you ever seen a mental health professional? If yes, was it helpful? Why or why not?

\_\_\_\_\_

\_\_\_\_\_

Have you been given a diagnosis by a mental health professional? If so, please explain:

\_\_\_\_\_

### **SBCC Client information sheet continued**

Please list any medications that you are currently taking, including supplemental vitamins:

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Do you have a history of seizures and/or a head injury? If yes, briefly explain:\_\_\_\_\_

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Do you have a history of allergies to medications? If so, please list:

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Please explain briefly why you are here today:\_\_\_\_\_

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Do you have a religious affiliation? ( )Yes ( )No  
Are you an active member of that organization? ( )Yes ( )No

In case of emergency, please call:\_\_\_\_\_

Phone number of emergency contact:\_\_\_\_\_

Relationship to client:\_\_\_\_\_

Your initials\_\_\_\_\_ Date\_\_\_\_\_