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Client Information Sheet

Today's date: _____

Full Name: _____

Date of Birth: _____

Address: _____

Email: _____

Phone: (hm): _____; (wk): _____; (cell): _____

Is it OK to leave a message at these numbers for you? _____

If not, how would you like me to contact you?

Occupation: _____

Place of employment: _____

Marital Status: _____

Spouse/Partner's Name: _____

Contact, in case of emergency (Name and Phone): _____

How did you hear about Phase 3 Counseling & Consulting? _____

What brings you to Phase 3 Counseling & Consulting at this point in time?

What are your goals for counseling, (i.e., what do you hope to accomplish during these sessions?)

What strengths do you bring with you that will assist you in working with these issues?

Previous counseling experience? Yes___ No___ Was it helpful? _____

Issues for previous counseling: _____

Name of previous counselor: _____

Medical/Psychiatric History:

Primary Care Physician: _____ Phone # _____

Psychiatrist: _____ Phone # _____

Please list any medications you are currently taking: _____

Any current medical conditions: _____

Any previous inpatient hospitalizations: _____

Any other information you feel would be helpful to share: _____