

**Client Information Form**

Prodigal Counseling  
Sean M. Jackson, MA, LMHC  
1817 Queen Anne Ave N, Suite 409  
Seattle, WA 98109

TaxID#602511632  
sean@prodigalcounseling.com  
(206) 369-4792

Name(s): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (message: yes or no) \_\_\_\_\_

Phone (work): \_\_\_\_\_ (message: yes or no) \_\_\_\_\_

Phone (cell): \_\_\_\_\_ (message: yes or no) \_\_\_\_\_

Any calling restrictions:

How did you hear of my services, referral source: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Insurance info: \_\_\_\_\_

Reason for seeking therapy at this time: \_\_\_\_\_

Positive changes since scheduling appointment: \_\_\_\_\_

Have you previously attended therapy? (yes or no). If yes, please provide dates, therapy focus, and name of provider: \_\_\_\_\_

**Individuals in the home (including your self):**

	Name	Birthdate	Age	Relationship	Employer/School
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

**Other significant members not in the home:**

	Name	Birthdate	Age	Relationship	Employer/School
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____

Other information you believe would be helpful for me to know at this time: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_