Client Information Form - General

<table>
<tr><td>Date:</td><td>Last Name:</td><td colspan="2">First Name:</td><td>Middle:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td>Age:</td><td colspan="2"></td></tr>
<tr><td colspan="2">Address:</td><td>Apt:</td><td>City, State:</td><td>Zip:</td></tr>
<tr><td colspan="2">Gender:
___ Male
___ Female
___ Transgender (Male)
___ Transgender (Female)</td><td colspan="2">Race:
___ African American
___ Caucasian
___ N. American Indian
___ Asian/Pacific Islander
___ Hispanic
___ Multi
___ Other</td><td>Relationship Status:
___ Married
___ Domestic Partner
___ Single
___ Separated
___ Widowed
___ Divorced</td></tr>
<tr><td colspan="5">First Phone Number: (_____) _____ - ___________________
Please indicate ___ Cell ___ Work ___ Home ___ OK to call ___ OK to leave message

Second Phone Number: (_____) _____ - ___________________
Please indicate ___ Cell ___ Work ___ Home ___ OK to call ___ OK to leave message</td></tr>
<tr><td colspan="5">Emergency Contact Phone Number:
Name of Contact Above: Relationship:</td></tr>
<tr><td>Disability:
___ Physical
___ Mental
___ Both
___ None
___ Unknown</td><td>Health Insurance:
___ Yes
___ No</td><td>Employment:
___ Full Time
___ Part Time
___ Retired
___ Unemployed</td><td colspan="2">Job Title:
________________</td></tr>
<tr><td colspan="2">Total # in household: ___________</td><td colspan="2">If children, please list their ages:
___________, ___________,
___________, ___________,
___________, ___________,</td><td>Is English your first language:
___ Yes
___ No</td></tr>
<tr><td colspan="5">How did you hear about us?
___ JCC client ___ Friend ___ Family Member ___ Counselor ___ Website
___ Phone Book ___ Brochure ___ Physician ___ Agency, Name: __________________</td></tr>
</table>