Confidential Client Information

Date: __________________ Referred by: _____________________________________

Client Name: _________________________ Age: ________ Date of Birth: _________

Home Address: ____

____

Cell Phone: ________________ Other: ________________ Email: __________________

Insurance Company: __________________________ MRN# ______________________

Phone# _____________________________ Policy# ____________________________

Social Security Number: _____________________ Driver's License:________________

Occupation: __________________________ Education Level:______________________

Relationship Status: (Check one)

Married _____ Partner ______ Single ______ Separated _____ Divorced ______

Partner/Spouse Name: ____Age _______

Occupation: ____

Children's Names and Ages:

____

____

____

Were you raised by: (check one)

Both parents _______ Single parent _______ Relative _______ Other _______

Mother's Name: ________________________ Age: ________ Deceased? _________

Father's Name: _________________________ Age: ________ Deceased? _________

Brother(s) and/or Sister(s) Names and Ages:

Why are you seeking counseling?

Do you or any of your family members or significant other have a history of:
(Check all that apply)

______Alcoholism

______Drug Abuse (prescription and or street drugs)

______ Domestic Violence

______ ADHD

______ Depression

______Prolonged illness

______Eating Disorders

______Other

If you checked any of the boxes please explain who had the problem and provide details (dates, severity, and nature of the problem etc.):

Are you taking any medications? Yes______ No______ If yes, please list Medication and Dosage and Purpose:

Do you have any significant physical problems? Yes ______ No ______
If yes, please explain:

Is there any other information that you think may be significant? Yes _____ No ______
If yes, please explain:

Do you have a Primary Care Physician? Yes___ No ___ If yes, please provide the following information:

Physician's Name: ____

Address: ____

Phone number: ____

Are you seeing a Psychiatrist? Yes__ No__ If yes, please provide the following information:

Psychiatrist's Name: ____

Address: ____

Phone number: ____

Do I have your permission to contact your Physician and tell him/her that you have entered treatment with me and coordinate services if necessary? Yes ________ No _________

If you answered no, please tell me why:

Have you had any previous psychiatric care or counseling? Yes______ No ________

If yes, please provide the approximate dates of treatment and reasons you sought help:

Have you ever been hospitalized for a mental disorder, drug or alcohol problem?
Yes _____ No_____
If yes, please explain:

Have you, any of your family members or significant other attempted suicide?
Yes _____ No _____
If yes, please explain:

Are you suicidal now? Yes______ No ______

Emergency Contact: _________________________ Phone: _____________________

Relationship to you: ____

I would like to be notified by mail of upcoming events and/or groups: Yes______ No _______

Client Signature __________________________________ Date ________________