CONFIDENTIAL CLIENT INFORMATION

Date:_____________________

Name:____ Birth date:____________________

Address:____ Age:__________________

City, State:_______________________________________ Zip code:_________________

Employer:_______________________________________ Occupation:_____________________

Address:____

Phone: Home:___________________________________ OK to leave message – yes no

Work:___________________________________ OK to leave message – yes no

Cell:____________________________________ OK to leave message – yes no

Email Address:___________________________________ OK to leave message – yes no

Relationship Status: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) In Relationship

How Long?_____________________

Partner Name:_______________________________________ Age:________________

Children/Others Living with You:	Age:	School/Occupation:	Grade:
Name:____________________________________	_____	_________________	__________
Name:____________________________________	_____	_________________	__________
Name:____________________________________	_____	_________________	__________
Name:____________________________________	_____	_________________	__________

Previous Marriage(s) & length of marriage(s): ____

Medical Information

Primary Care Physician:_______________________________________

Last medical exam:________________________

Have you ever been diagnosed with a serious illness? Please describe: ____
____
____

Medications that you are currently taking:

____
____

Do you have any medical conditions that may affect your emotional health treatment? Please describe:____
____
____

Please describe your overall health today:____

Have you ever been in a 12-step program? Please describe:

____

Do you smoke?________ How much?______________ For how long?________________

Do you drink alcohol?________________

On average, how much alcohol do you consume in a week? ________________________________

Do you currently use recreational drugs? If so, please describe your use:

____
____

Have you ever used recreational drugs? If so, please describe:

____
____

Are you seeing a psychiatrist?

Yes _____ No _____ Last appointment:_______________________

Psychiatrist Name: ____

May I contact your psychiatrist? Yes _____ No _____

Circle any of the following problems that you experience:

Lack of appetite	Sleep disturbances	Flashbacks	Excessive drinking
Problem drug use	Panic Attacks	Anxiety	Loneliness
Nightmares	Sexual problems	Stomach problems	Low self-esteem
Depression	Appetite disturbances	Fears/phobias	Obsessive thoughts
Difficulty trusting	Relationship problems	Compulsive behaviors	Confusion
Marital/family problems	Pain	Difficulty concentrating	
Poor impulse control			

Family of Origin

Mother's Name: ____________________ Age: _________ Location:______________________

Mother's Health: _________________________ Profession: ____________________________

Father's Name: ____________________ Age: _________ Location:______________________

Father's Health: _________________________ Profession: ____________________________

Write 3 adjectives to describe your Mother:

1. ________________________
2. ________________________
3. ________________________

Write 3 adjectives to describe your Father:

1. ________________________
2. ________________________
3. ________________________

Health Checklist – check all that apply to each family member and yourself

	You	Partner/spouse	Child/children	Briefly explain
Anxiety				
Depression				
Drinking				
Substance Abuse				

Anger ____

Workaholism ____

Food addiction ____

Spending/gambling ____

Sex addiction ____

Physical health ____

Areas of Concern

What issues/concerns cause you to seek counseling? Please describe.

____
____
____

Do you have any specific goals with regard to your counseling?

____
____

Do you have any particular concerns/fears with regard to counseling?

____
____

What do you consider to be your strengths?

____
____

Do you have individuals/groups/values which support and nurture you? Please describe.

____
____

Prior history of counseling: Yes No

If yes, when and why did you seek therapy? Was it helpful? Please describe.

____
____

Name of prior therapists: ____

May I contact your prior therapist(s)? Yes No

Any additional information you would like to add?

____
____
____

Emergency contact: ____
Relationship:________________ Phone Number:____________________________________

How did you find out about me? __________________________________

May I thank someone for the referral? ____