CLIENT INFORMATION

Full Name ______________________________ Age ____________ Gender ______________

Preferred Name ________________________ E-mail ______________________________

Address __________________________City_______________ State________ Zip__________

Phone ____________________

Social Security Number ______________(optional) Date of Birth ______________________

Married ☐ Single ☐ Widowed☐ Divorced ☐ Separated ☐

Spouse (Partner) ________________________________ Age ______________

Your Occupation ___________________________ Employer ______________________

Work Address ____________________________________ Work Phone _______________

Education: Elementary/ Jr. High School ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Post Graduate ☐

Children (give ages) ____

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Medical Conditions ____

Medications ____

Physician ____________________ Address_______________________________

Phone _______________

Have you ever had counseling or therapy before? Yes☐ No ☐ If yes, please give dates and with whom ______________

____

May we contact former counselor/ therapist? Yes ☐ No ☐

Are you currently under psychiatric care? Yes ☐ No ☐ If yes, Psychiatrist Name ______________________

Address ______________________________________ Phone _______________

Are you currently taking any psychotropic medications? Yes ☐ No ☐ If yes, please list ______________________

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Who referred you? ☐ Insurance/EAP ☐ Internet Search ☐ Physician ☐ Phone Book ☐ Friend ☐ Other _______________

What problems are you having that caused you seek counseling/therapy or be referred?______________________

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Have you ever attempted suicide or had serious suicidal thoughts? Yes ☐ No ☐ If yes, are you having suicidal thoughts now? Yes ☐ No ☐

Have you ever been hospitalized for a mental condition? Yes ☐ No ☐ If yes, when did this occur and where? ______________

____

Emergency Contact ____________________________________ Phone ______________

To the best of my knowledge, the information given above is true and correct.

Signed __________________________________ Date ______________________