CLIENT INFORMATION

Name: _____ Date: _____
First Middle Last

Address: _____
Street

_____
City State Zip County

Home Phone:		Work Phone:
Cell Phone:		Email:
Birth Date:	Age:	SSN:
Marital/Relationship Status:	Date of marriage:	Spouse's/Partner's name:
Race:		Sex: ___ F ___ M
Education (highest completed):		Occupation/Title:
Employer:		Years with Employer:

EMERGENCY CONTACT INFORMATION

Name:	Relation:
Phone :	2nd Phone:

FAMILY/HOUSEHOLD

If there are any children living in your household, what are their names and ages?

_____

_____

Do you have any children that do not live with you? What are their names and ages?

_____

_____

Please list any other household members not included above (include names, ages, and relation):

_____

_____

CLIENT INFORMATION (continued)

Name: _____ Date: _____

COUNSELING HISTORY

Are you receiving other counseling services at present? Yes ____ No ____

If Yes, please briefly describe: _____

_____

Have you received counseling in the past? Yes _____ No _____

If Yes, please briefly describe: _____

_____

Have you ever had any suicidal thoughts? Yes ____ No ____
Are you currently experiencing any suicidal thoughts? Yes ____ No ____
Have you ever attempted suicide? Yes ____ No ____
Have you ever had any problems with alcohol or drugs? Yes ____ No ____
Have you ever been hospitalized for a mental health problem? Yes ____ No ____
How did you hear about this practice, or who referred you?

_____

MEDICAL HISTORY

Primary Physician's name: _____ Phone: _____

List any major illnesses, operations, or significant physical concerns you have experienced in the past:

_____

_____

List any physical concerns you are having at present: _____

_____

On average how many hours of sleep do you get daily? _____
Do you have any sleep difficulties? Yes ____ No ____

If yes, please briefly describe: _____
Describe your appetite for the past week: below average ____ average ____ above average ____
Have you gained or lost over ten pounds in the past year? Yes ____ No ____ gained ___ lost ___
If yes, was the gain or loss on purpose? Yes ____ No ____
Are you currently taking any medications? Yes ____ No ____
If yes, what medications (and dosages) are you taking at present, and for what purpose?

Medication	Dosage	Purpose

_____

_____

_____