

CLIENT INFORMATION

Full Name: _____ **Name You Prefer:** _____
Date of Birth: _____ **Age:** _____ **Gender:** _____ **Social Security #:** _____
Mailing Address: _____

Home Phone: () _____ **Okay to leave message? Yes/No**
Work Phone: () _____ **Okay to leave message? Yes/No**
Cell Phone: () _____ **Okay to leave message? Yes/No**
Email Address: _____

Emergency Contact: _____ **Relationship to You:** _____
Phone: () _____

Ethnicity: _____ **Birthplace (country/state):** _____
Sexual Orientation: _____ **Religious/Spiritual Preference** _____

Relationship Status: Single Committed Rel. Married Separated Divorced Widowed

Highest Degree Earned: _____ **School/College:** _____
Occupation: _____ **Employer:** _____

Service you are requesting:
 Individual Therapy Couples Therapy Family Therapy Group Therapy

CLIENT HISTORY

Please list everyone living in your household and their relationship to you:

<u>Name</u>	<u>Age</u>	<u>Gender</u>	<u>Relationship to You</u>
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Please briefly describe concerns or problems that bring you to therapy at this time:

Please circle any of the following areas of concern, either past or present:

- | | | | |
|--------------------------|--------------------------------|-------------------|----------------|
| Alcohol/Drug Abuse | Hopelessness | Paranoia | Anger Control |
| Homicidal Thoughts | Parenting Concerns | Anxiety | Hostility |
| Phobias/Panic | Assertiveness | Isolation | School |
| Attention/Concentration | Impulse Control Problems | Bereavement/Grief | Self-Defeating |
| Insomnia | Self-Esteem Issues | Communication | Irritability |
| Self-Injurious Behaviors | Depression | Identity Issues | Sexual Abuse |
| Work Problems | Legal Issues | Sexuality | Spirituality |
| Domestic Violence | Marital /Relationship Problems | Stress | Eating/Food |
| Medical Concerns | Suicidal Thoughts | Memory | Family |

Have you been in counseling/therapy or hospitalized before? Yes No

Date Nature of Problem Therapist/Hospital Benefit from therapy?

Current medications:

Medication Dosage Reason for Use Prescribing Physician

Please describe use of alcohol, tobacco, or other substances:

Substance Frequency of Use

Please describe any trauma you may have experienced (i.e. abuse, severe car accident, death of a loved one/pet, severe illness, natural disaster):

Description of trauma Age/Year

Please list anyone in your family who has been in therapy or diagnosed with any type of mental illness:

Relationship to You Problem Nature of treatment, if any

Medical Concerns: _____

Primary Physician: _____ Date of Last Visit: _____

Please list any other information you would like me to know:

REFERRAL INFORMATION

Referred by: _____

Do we have your permission to thank your referral source? YES / NO