Client Information

Please tell me about yourself:

Name_____
Age_____
DOB: _____

Contact information:

Address: _____
Phone number: _____
Email: _____
Is it ok to email you to confirm appointments? Yes No

Referral Source:_____
Insurance Company: _____--
Insurance ID: _____
Phone number on the back of insurance card _____
Are you the primary insured in the policy _____
If not, please list the name of the primary insured _____

Relationship status _____Years_____

Have you received counseling services in the past? If so, please list when and purpose:
_____
_____
_____

Please list any significant health problems you have
now_____
_____
_____
_____
_____

Please list all medications (prescribed or over-the-counter) which you take:
_____
_____
_____
_____

Have you ever been hospitalized for mental health reasons? If yes, when and why:

_____
_____
_____
_____

Have you ever attempted suicide? If yes, when and how:

_____
_____
_____
_____

Please mark any of the following, which are currently problems for you:

Depression	Stress	Self-esteem
Fears	Sexual problems Suicidal	Panic
Sleeping	thoughts Anger	Guilt
LGBT Issues Alcohol/drug	Terminal Illness Disturbing	Anxiety
use Eating problems	Thoughts Health	Memory/Concentration Perfectionism
Fearing failure Making	Relationship Problems	Obsession/Compulsion
decisions	Death of loved one	Legal Matters
		Other _____

What is your average *weekly* intake of alcoholic drinks? _____ per week.

Any recent increase?_ _____

At the time of your life when you were drinking the most, how much did you drink *weekly*?_____

List any other kinds of drugs you sometimes use, or have used in the past, legal or illegal including frequency of use:

_____
_____
_____
_____

Abuse/Trauma History:

Please mark any that you have experienced personally or that have happened to others and have significantly impacted your family:

Physical Abuse

Sexual Abuse

Emotional Abuse

Witnessed violence

Serious illness/injury

Sudden death of a loved one

Loss of home

Loss of Job

Other_____

Family & significant others:

Mother (age/quality of your relationship)
_____

Father (age/quality of your relationship)
_____

Still married to each other? _____
Your age when they split up? _____
Spouse/Partner (name & age):
_____
_____
_____

Sisters & Brothers (first name & age):
_____
_____
_____
_____

Children (first name/age/other parent if different than current partner):
_____
_____
_____
_____

Married previously? _____
How long were you married? _____
When/why did relationship end?
_____
_____

Has any *biological* family member ever had a drinking or drug problem, depression, nervous breakdown, mental disorder, or attempted suicide? Please describe:
_____
_____

_____
_____

What is your goal for counseling (what do you want to be different in your life)?

_____
_____

THANK YOU