

CLIENT INFORMATION

Name: _____

Date of birth: _____ Place of birth: _____

Age: _____ Marital status: _____ Religion: _____ Race: _____ Gender: _____

Address: _____ City: _____ State: _____ Zipcode: _____

Social Security Number (only if using insurance): _____ Email: _____

Telephone: (H) _____ (C) _____ Occupation: _____

Education completed: _____ Where: _____

Name(s) and age(s) of child/children: _____

Have you (or your partner) ever been involved in therapy or any other type of counseling program?

() Yes () No

If yes, when? _____ Where? _____

Reasons: _____

Reasons for considering therapy at this time: _____

Are you in treatment with another counselor at this time? () Yes () No If yes, with whom? _____

Have you ever been hospitalized for any mental health problems? () Yes () No

If yes, when? _____ Where? _____ By whom? _____

Have you ever contemplated suicide? () Yes () No

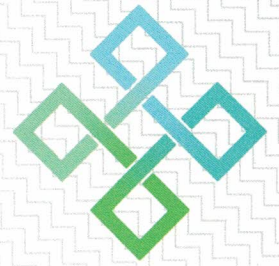
Have you ever attempted suicide? () Yes () No

Are you currently suicidal? () Yes () No

Have you ever been, or are you now being, treated for any type of chemical dependency or abuse?

() Yes () No If yes, when? _____ Where? _____

By whom? _____ Length of treatment? _____



Are you at the present time using any type of chemical substance? () Yes () No

If yes, please indicate what you are using (drugs/alcohol): _____

How frequently do you use these substances? _____

Are you presently under a physician's care for physical problems? () Yes () No

If yes, please list medication(s): _____

Name of physician: _____ Telephone: _____

Have you ever been arrested and/or committed a crime? () Yes () No

If yes, when? _____ For what? _____

Outcome of situation: _____

What problems are you presently experiencing? (Social/financial/occupational/relational/familial/legal)

What do you expect from therapy? _____

Please list everyone in your family with whom you presently live: _____

Identify the primary problem(s) you are now experiencing: _____

If need be, would other relatives be willing to come to therapy sessions? () Yes () No

If no, please indicate the reason: _____

Primary emergency contact: _____

Relationship to client: _____ Telephone: _____

Permission to contact in an emergency? () Yes () No

Signature: _____ Date: _____