CLAUDIA RIEMAN, PH.D.
1948 E. Sunrise Blvd. Suite 8 Fort Lauderdale, FL 33304 954-336-1105

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?_____

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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:_____