CLIENT INFORMATION
For Office Use only

Date: ____________

NAME: ________________________________ DOB: _________________

Soc. Sec. _____________________. Gender:_____

RACE:_____ Native American _____ Black/African American
_____ Caucasian _____ Hispanic/Latino
_____ Asian _____ Other

ADDRESS
____
____

MARITAL STATUS (circle one) S M D W SEP.

How is your relationship with your significant other?

From time to time we may need to contact you by phone. May we leave a message on your voice mail?: Yes: _____ No: _____
Home: ________________ Cell: _________________ Office: _______________
Email Address: ________________________________
Facebook: ________________________________
Twitter: ______________________________________
Emergency Contact:
Name:_______________________
Number:_____________________
Relationship:____________
Occupation: _____________________________
Employer: ______________________________
Work Address: ____
____
Length of employment: _________

Insurance:
Medicaid No.:____________________________
Private Insurance and policy number and phone number:
____
Education: ____

Partner or Parent’s Name: ___________________________________
Address: ____
____

Home Phone: ________________________ Work Phone: ___________________
Employed by: ____
Education: ____
Length of Employment: __________

CHILDREN SCHOOL AGE GRADE

____
____
____
____

Religious Affiliation: ____
Doctor's Name and Phone No.: ____
Nearest Relative Or Close Friend: ____
Phone No.: __________________________
Referred By: _________________________

May we have permission to thank your referral source. Yes: _____ No.: _________
Do you need a statement to file with your insurance company? Yes: _____No: _________

REASON FOR SEEKING COUNSELING AT THIS TIME

____
____
____
____
____
____
____

Do you, your spouse or other significant people in your life have any health problems? If so, please explain.

____
____
____
____

Current Medications

____
____

Have you had prior psychotherapy? Yes or No. If yes, when and with whom?

____
____

Are you presently having suicidal thoughts? Yes: ________ No: _______
Have you ever attempted suicide or wanted to commit suicide? Yes: _____ No: _________

Do you physically hurt yourself? Yes: _____ No: __ If so, when was the last time that you did?____
Have you ever been physically or sexually abused? Yes: _________ No: _________
If Yes, please explain? ____
____
____
____

CIRCLE YES OR NO
Have you been feeling down, depressed, or hopeless in the past month? Yes or No
Has your appetite changed (eating more or less)? Yes or No
Has your sleep been disturbed (insomnia or over-sleeping)? Yes or No
Do you feel worthless or guilty? Yes or No
Do you often feel tense, worried, or stressed? Yes or No
Do you worry about a lot of different things? Yes or No
Do you avoid places or situations because of anxiety or worry? Yes or No
Have there been any significantly stressful periods over the past 6 months? Yes or No
Do you drink or use any type of drugs? Yes or No
Do you feel guilty about your drug use? Yes or No
Are you having problems functioning at work and home? Yes or No

Did you have a happy childhood? Yes or No
Were you raised by your parents? Yes or No
How is your relationship with your parents now?

How many times have you been married. ___
If married, how is your relationship with your spouse? ______________________________
____
What are the present problems in your household? __________________________________
____

Any additional information you would like to share.
____
____
____