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

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

Name	**Age**	**Gender**	**Relationship to You**

CLIENT HISTORY

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