Client Information

Today's Date_________________________

Name:____ **Birth Date**:____________________________

Address:____

Street State Zip

Home Phone:____ OK to Leave Message: Y___ N___

Work Phone: ____ OK to Leave Message: Y___ N___

Cell Phone: ____ OK to Leave Message: Y___ N___

Emergency Contact:

Name: _____________________________________ Phone: _______________________________________

Referred by____

It is ok to thank the person who referred me:_____ It is not ok to thank the person who referred me:______

Please initial Please initial

Primary Care Physician: ____

Phone/Address:____

Prescribing Physician (if different from Primary Care):____

Phone/Address:____

Current Medications: (Drug Name, Dose, and date you began medication)

________________________ ______________________ _________________________

________________________ ______________________ _________________________

________________________ ______________________ __________________________

Occupation/Place of Employment:____

Any work related problems? ____

____

Military History:____

School History: Last Grade completed_____________

Specific Learning Disabilities____

Learning Strengths____

Alcohol and Drug History: (Please list age when started and types of substances used through the years and current usage)____

____

____

Have you ever felt you should cut down on your drinking or drug use? __________________________

Has anyone ever told you they thought you should cut down on your drinking or drug use? (If yes, please explain) ____

____

Have you ever felt bad about cut down on your drinking or drug use? ___________________________

Have you ever used drugs or alcohol first thing in the morning? ________________________________

Caffeine use per day ____

Nicotine use per day (past and present)____

Family Structure (who lives in your current household, please give ages and relationship to each person): ____

____

Siblings: (names. ages,)____

____

Is there a family history of Mental Health Treatment/ Diagnosis? (If yes, please explain): _____________

____

____

Children: (Names, ages, problems, strengths) ____

____

Cultural/Ethnic Background: ____

Describe relationships with Friends/Supports: ____

____

Reason for Seeking Therapy: ____

____
____
____
____

Please check any symptoms you have or are currently experiencing:

Current ___ Past___ **Sleep Disturbance**

Current ___ Past___ **Stress**

Current ___ Past___ **Low Energy**

Current ___ Past___ **Obsessions/Compulsions**

Current ___ Past___ **Irritability**

Current ___ Past___ **Panic Attacks**

Current ___ Past___ **Binging/Purging**

Current ___ Past___ **Appetite Disturbance**

Current ___ Past___ **Reaction to Trauma**

Current ___ Past___ **Depressed Mood**

Current ___ Past___ **Poor Concentration**

Current ___ Past___ **Anxiety**

Current ___ Past___ **Phobias**

Current ___ Past___ **Anorexia**

What would you like to accomplish in Therapy? ____

____
____
____

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