

**PERSONAL INFORMATION**

Today's Date: \_\_\_\_\_

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**Client Information:** Client's Name: \_\_\_\_\_

first

middle

last

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Work Telephone #: \_\_\_\_\_

**Please circle the Telephone Numbers you want me to use when I need to contact you. If the address you want me to use for mailing is different than the one listed above write it here:** \_\_\_\_\_

Employer: \_\_\_\_\_

Needed for Billing Insurance: \_\_\_\_\_ Date of Birth of Insurance Policy Holder: \_\_\_\_\_

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**Emergency Contact Name:** \_\_\_\_\_ Phone #: \_\_\_\_\_

**Family / Relationship:** (Circle): SINGLE COHABITATING ENGAGED MARRIED SEPARATED DIVORCED WIDOWED

Client's Partner Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Biological Children: (Name, Age, Sex, Residence) \_\_\_\_\_

List all others in household: (Name, Age, Sex, and Relationship to You) \_\_\_\_\_

**Education:** (Level, Focus) \_\_\_\_\_

**Military Service** (Circle): **Y N** \_\_\_\_\_

**Legal History:** \_\_\_\_\_

Are your reasons for seeking help at this time associated with the legal system?: **Y N**

If yes, are you currently on probation or parole?: **Y N**

**Faith Preference/Spirituality:** \_\_\_\_\_

**Recreation/Relaxation/Exercise Habits:** \_\_\_\_\_

**Health Information:**

Primary Care Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Approximate date of last medical examination: \_\_\_\_\_ Permission to contact your physician: **Y N**

Specialists Consulted Recently: \_\_\_\_\_

Recent Changes(Unintentional):

Weight change in the past 6 months: Y N \_\_\_\_\_

Significant appetite change over the past month: Y N \_\_\_\_\_

Sleeping change in the past 6 months: Y N \_\_\_\_\_

Health Problems & Concerns:

Major illnesses or surgeries: Y N \_\_\_\_\_

Drug/food allergies: Y N \_\_\_\_\_

Chronic physical health problems, conditions, impairments, or limitations which may require special accommodations, arrangements, or may affect your treatment (i.e., Reading Difficulties, Hearing Loss, Vision Loss, or Speech Impairment)? :

Y N (If yes, please list): \_\_\_\_\_

Previous participation in counseling, psychotherapy, psychiatric treatment, alcohol, or addiction treatment? :

Y N (If yes, please list with approximate dates): \_\_\_\_\_  
\_\_\_\_\_

Have you previously taken medication for a mental health condition? :

Y N (If yes, please list) \_\_\_\_\_

Substance Use:

Current or previous use of tobacco products: Y N \_\_\_\_\_

Current or previous use of alcohol: Y N \_\_\_\_\_

Current or previous use of illegal drugs: Y N \_\_\_\_\_

"Over-the-counter" medications you frequently use: \_\_\_\_\_

Herbal remedies you currently use: \_\_\_\_\_

Prescribed Medications You Currently Use (Omit If You Brought a Separate List):

<u>Medication</u>	<u>Purpose</u>	<u>Dosage/Times Per Day</u>	<u>For How Long?</u>	<u>Do You Take It Consistently?</u>
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N
_____	_____	_____	_____	Y N

Why did you seek treatment at this time?: \_\_\_\_\_

What Improvements, Information, or Changes do you seek?: \_\_\_\_\_  
\_\_\_\_\_

How were you referred to my practice? \_\_\_\_\_

List reasons you selected me to work with: \_\_\_\_\_