

Client Information

Today's date: _____

A. Identification

Your name: _____ Date of Birth: _____ Age: _____

Social Security Number: _____ Nicknames/Aliases: _____

Home street address: _____ Apt. number: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Calls will be discreet, but please indicate any restrictions: _____

Work and/or Cell numbers: _____

Email Address (if applicable): _____

B. Referral: Who gave you my name to call?

Name/Source: _____

C. Your Health Insurance:

Health Insurance Company: _____ Phone number (on back of your insurance ID card): _____ Insurance ID number: _____

Health Insurance Group Number: _____ If under other's insurance, their name: _____ their relationship to you _____

their date of birth: _____ their place of employment: _____

If EAP (Employee Assistant Program), EAP name: _____

If provided by insurance or EAP for this referral, Authorization #: _____

D. Your current employer

Employer: _____ Address: _____

Work phone: _____ Calls will be discreet, but please indicate any restrictions:

E. Your education and training

If currently attending school, what grade are you in? _____

What school do you attend? _____

Address of school _____

High School Diploma? _____ Yes _____ No

College? Please list your highest degree: _____

F. Marital/ Relationship History

Please select one:

_____ Single

_____ Married (years = _____) This is my _____ (first, second, etc.) marriage

Dates and duration of previous marriage(s), for example: First, married 06/90, divorced 07/96

Divorced (years = _____)

G. Children

Number of children (if applicable) : _____

Ages, gender and names:

H. Treatment

1. Have you ever received psychological or psychiatric or counseling services before?

_____ Yes _____ No

If yes, please indicate:

When? _____

From Whom? _____

For What? _____

With What Results? _____

2. Have you ever taken medications for psychiatric or emotional issues? _____ Yes _____ No

If yes, please indicate:

When? _____

From Whom? _____

For What? _____

With What Results? _____

3. Relationships in your family of origin: Please describe the following:

1. Your parents' relationship with each other: _____

2. Your relationship with each parent and with other adults presently: _____

3. Your parents' physical health problems, chemical/substance use, and mental or emotional difficulties: _____

4. Your relationship with your brothers and sisters, in the past and present: _____

I. Abuse history:

Check one of the following:

_____ I was not abused in any way or _____ I was abused If you were abused, please indicate in what way (examples: emotional, physical, sexual, neglect): _____

J. Present Relationships

1. How do you get along with your present spouse, partner, or parents/siblings? _____

2. How do you get along with your children? _____

K. Chemical/Drug Use

1. Have you ever felt the need to cut down on your drinking? _____ Yes _____ No

2. Have you ever felt annoyed by criticism of your drinking? _____ Yes _____ No

3. Have you ever felt guilty about your drinking? _____ Yes _____ No

4. How much beer, wine or hard liquor do you consume each week, on the average? _____

5. How much tobacco do you smoke or chew each week? _____

6. Which drugs (not medications prescribed to you) have you used in the last 10 years, and approximately when was your last use of each? _____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth. Please include any pain medications you have taken in the past year : _____

L. Legal History

Have you had any legal trouble in the past 10 years (not including traffic/parking violations?)

_____ Yes _____ No If yes, please describe: _____

M. Your Goals for Therapy

Please describe what has brought you to see me today, including what you would like to accomplish in therapy: _____

Please give this form to your counselor when you have finished.