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: _________________________

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____

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: ____________________

____

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____

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? ____

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____

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.