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Client Information

Date: _____

Name: _____

Address: _____

Social Security No.: _____

Telephone No.: (H) _____ (W) _____

Age: _____ Date of Birth _____ Place of Birth _____

Check as many as apply: Committed Relationship _____ Single _____ Divorced _____ Separated _____

Highest level of education attained: _____

Name of child/children:	Age:	Date of birth:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever been involved in therapy or any other type of counseling program? ☐Yes ☐No

If yes, when? _____ Where? _____

Reasons: _____

Reasons for considering counseling at this time: _____

_____

Were you referred to this counseling office? ☐Yes ☐No If yes, by whom? _____

Are you in treatment with another counselor presently? ☐Yes ☐No

If yes, with whom? Name: _____How long? _____

Have you ever been hospitalized for any mental health reason? ☐Yes ☐No

If yes, when? _____ Where? _____

Reason: _____

Are you receiving medical treatment from a psychiatrist? ☐Yes ☐No

If yes, with whom? Name: _____ Phone _____

Have you ever, or are you now being treated by any type of chemical dependency abuse? ☐Yes ☐No

If yes, when? _____ Where? _____

By whom? _____ Length of treatment _____

Are you using any type of chemical substance at this time? ☐Yes ☐No

If yes, please indicate what you are using: _____

How frequently do you use these substances? _____

Are you presently under a physicians care for physical problems? ☐Yes ☐No

If yes, please list reasons and any medications: _____

_____

Name of family physician: _____ Phone: _____

What problems are you experiencing at this time? _____

_____

_____

What do you expect from therapy? _____

_____

_____

Please list everyone with whom you presently live: _____

_____

_____

What resources do you have (internal and external) that help you feel a bit better when you think about them?_____

_____

____

Person to contact in case of an emergency: _____ Phone: _____

Address: _____

_____

_____ Date:_____

(Signature)