CLIENT INFORMATION

Name:____

Date of birth: ____________________

Address: ____

City: ___________________________________ **State:** ___ **Zip:**___________________

Cell #: _______________________ **Other phone #:**________________________

Email address: ____

EMERGENCY CONTACT

Notify: ____ **Phone # :** _______________

Relationship to client: ____

INSURANCE

Insurance provider: ____

Primary insured's name: ____

Primary insured's date of birth : ____

Policy #: ____

Group #: ____

Effective date: ____

HEALTH INFORMATION

Name of your primary care physician: ___________________________________

Primary physician's office phone #: ____________________________________

Are you currently taking any medications? Please list them: _________________

____

____

SYMPTOM ASSESSMENT

Briefly describe your reason for seeking counseling services:

____

____

____

____

Please give an accurate account of your symptoms. This will help you get the most out of counseling.

Please circle all that apply.

Anger Anxiety Depression Grief/loss Eating Disorder Fear/Phobia

Sexual concerns Relationship concerns Drugs/alcohol Sleeping concerns

Impulsivity Mood swings Social concerns Divorce Legal concerns

Employment concerns Education concerns Panic attacks

Other concerns: ____

History of trauma: Circle all that apply.

Emotional abuse Physical abuse Sexual abuse Traumatic event

I use the following	Seldom	Often	Daily	Never	For how long?
Alcohol					
Nicotine(cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					

PERSONAL AND FAMILY HISTORY

Have you ever been hospitalized for a psychiatric illness?

Has a close relative ever been hospitalized for a psychiatric illness?

Does anyone in your family have a mental illness?

Has anyone in your family ever attempted or committed suicide?

Does anyone in your family have a substance abuse problem?

Have you ever been arrested?

Client signature: ______________________________________ **Date:** ______________