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Client Information

Name_____Age_____

Address_____City/State_____

Phone cell_____Work_____

Employer_____Occupation_____

School_____ Grade____

Referred by_____ May I Thank Them? Yes No

Emergency Contact:_____Phone #_____
_____Relationship_____

Religious Affiliation_____ Highest level of education_____

Are you: Single Married Divorced Widowed Separated

Partner/Spouse
Name:_____

List all those who live in your household:

Name_____Age_____Relationship_____

Name_____Age_____Relationship_____

Name_____Age_____Relationship_____

If your child is under 18 who has custody:

Both_____ Mother_____ Father_____ Relative_____ Other_____

Parents:

Name_____DOB_____Phone#_____

Name_____DOB_____Phone#_____

Name_____DOB_____Phone#_____

Name_____DOB_____Phone#_____

Physician Name_____

Address_____City/State_____

Zip
Code_____Phone#_____

Describe any current our past major medical
problems_____
_____
_____
_____

Date of last physical_____

Previous Hospitalizations:

Date Issue

_____
_____
_____
_____
_____
_____

List any Medications you are currently taking

_____
_____
_____

Please circle any problems you have had or are experiencing currently:

School Family issues

Work Medical issues

Relationship issues Divorce

Grief/Loss Stress

Difficulty Concentrating	Excessive Worry
Hyperactivity	Attention Deficit
Anger issues	Depression/Sadness
Anger issues	Alcohol/Drug Abuse
Sexual Abuse	Physical Abuse
Sleep Problems	Anxiety
Excessive Energy	Panic Attacks

Have you been in therapy before? Yes No

What were the previous issues?_____
_____
_____

Have you experienced any major life changes in the past three years? Yes No

Describe those changes_____
_____
_____
_____

What are your goals for therapy?_____
_____
_____
_____
_____
_____