CLIENT INFORMATION SHEET

Identifying Information

Client's name: ____ Today's Date: ____________________

Partner's Name (if being seen as a couple): ____

Address: ____City, State, Zip __________________________

Telephone(s): ______________________ (home) _________________________ (client work #) _______________________ (partner work #)

May we leave messages for you at home? Yes____ No ____ May we leave messages at work? Yes ____ No ____

Gender: M ____ F ____ Age: _______ Birth Date: ______________________ Marital Status: ______________________

Others living in the home: _________________________________ (name, birthdate, relationship to client), ___________________________________ (name, birthdate, relationship to client),

____________________________ (name, birthdate, relationship to client), _______________________________ (name, birthdate, relationship to client), ______________________________ (name, birthdate, relationship to client)

Education: Client_ __________________________________ Partner ________________________________

Occupation: Client __________________________________ Partner ________________________________

Client's Employer: ____

Social Security (ID) number: Client _____________________________ Partner (optional) _________________________

Emergency Contact: ____ Phone: ________________________

Referred by: ____

Insurance Information

Name of Insured : ____ Insured date of birth: ________________

Address of Insured: ____ City, State, Zip: ___________________

Relationship of client to the Insured: ______________________________

Employer of the Insured: _______________________________________

Insurance company: ____ Phone: ________________________

Insurance company address: ____________________________________ City, State, Zip: ___________________

Insurance identification number: _________________________________ Group number: ___________________

Secondary insurance: ____ Phone: ________________________

Name of secondary Insured: _____________________________________ Date of birth: _____________________

Secondary company address: ____________________________________ City, State, Zip: ___________________

Secondary identification number: _________________________________ Group number: ___________________

Patient or Authorized Person's Signature

“I authorize the release of any medical or other information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.”

Signature: ____ **Date:** _________________________

Client Name____ File # ________________________

Presenting Problems

Describe the problems that brought you here today: ____

____

____

____

Circle any of the symptoms that you are experiencing:

Depression	Change in sexual interest or function	Sudden feelings of panic
Feeling hopeless	Trouble performing your job	Physical complaints of pain
Extreme sadness	Problems getting along with friends/family	Muscle tension
Feeling tearful	Lack of enjoyment in usual activities	Problems with anger
Trouble concentrating	Self-esteem problems	Acting violently
Problems sleeping	Easily irritated	Thoughts of hurting yourself or others
Memory problems	Perfectionism	Thoughts of killing yourself or others
Lack of energy	Feeling guilty	Feeling fearful
Change in eating habits	Obsessions or compulsions	Feelings of extreme happiness
Weight changes	Feeling nervous	

Family History

	NAME	AGE	If living, City & State of residence If deceased, year of death
Father			
Mother			
Step-parent			
Step-parent			
Brothers & Sisters			

Partner History	Name of Previous Spouse/Partner	Date of Marriage/ Loving Together	Date of Divorce/ Separation

Children: Please list all of your children (both living and deceased)

Name	Birth date or Age	Gender

Client Name____ File # ________________________

Did your parents divorce or separate? Yes No If yes, how old were you? ____________

With whom did you live while growing up? ____

Have you been physically abused? Yes No Don't remember

Have you been sexually abused? Yes No Don't remember

Did you witness abuse between parents? Yes No Don't remember

Did you witness abuse between parents & children? Yes No Don't remember

Have you ever considered or attempted suicide? Yes No If so, when? ____________________

Have other members of your family attempted or committed suicide? Yes No

If so, who and when? ____

Have you had any previous counseling experience or psychiatric hospitalization?

Yes No If so, when and with whom? ____

Was it helpful? Yes No Explain please ____

Medical Information

Have you seen a doctor or doctors within the past year? Yes No

Who and Why? ____

____

____

What medicines (prescribed or over-the-counter), herbs and vitamins do you take? (Include the name of the prescribing doctor)

____

____

____

Do you have allergies? Yes No Describe allergy problems: ______________________________

____

Do you use tobacco? Yes No If yes, what kind and how much daily? ______________________

Do you drink caffeine (coffee or tea)? Yes No If yes, how many cups a day? ______________________

How much alcohol do you drink? (average number of drinks per week)

0 1-5 6-10 11-20 over 20

What other drugs do you use? ____

How often? ____

Has your use of alcohol or other drugs caused problems or been a concern to you or others? Yes No

Have you sought treatment for problems with alcohol or other drugs? Yes No

If yes, when and where? ____