

Client Information

Client Name _____ Date of Visit _____

Address _____ City _____ State _____ Zip _____

Home Phone No. _____ Business Phone No. _____

Cell Phone No. _____ Additional Phone No. _____

Birthdate _____ Age _____ Marital Status _____

Spouse's Name and Age _____

Names and Ages of Children _____

Other Individuals Living at Home _____

Occupation _____ Current Employment _____

Length of time at Current Employment _____

Level of Education _____ Military History _____

Referral Source (or how did you locate me) _____

Medical History:

Current Medical Conditions _____

List Current Medications _____

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Surgical Procedures (include year surgical procedure performed) _____

Client Information

Previous Therapy Experience (please list reason treatment was sought, year and length of treatment)_____

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History of Inpatient Treatment (please list year and length of treatment)_____

Why are you seeking assistance at this time?_____

Recent event that contribute to your current emotional distress_____

Please specify and describe whether you are experiencing any of the following symptoms.

Change in Mood_____

Anxiety or Nervousness_____

Agitation or Irritability_____

Sleep Disturbances (including difficulty falling or staying asleep, early awakening)_____

Change in Appetite (including increase or decrease)_____

Weight change (increase/decrease)_____

Behaviors that may be of concern_____

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Please specify the use of any compulsive/addictive behaviors (include amount and frequency of use).

Alcohol_____

Prescription, Over-the-Counter, or Other Substances_____

Gambling_____

Other behaviors that may be of concern_____

Please describe and list the members of your family of origin (please include approximate age).

Mother_____

Father_____

Married or Divorced (please include your age at the time of the divorce)_____

How would you describe their marriage_____

Siblings (include age, marital status, number of children and a brief description.

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Notify in an emergency:

Name _____ Relationship _____

Phone Nos. _____

I understand that I am responsible for payment of services rendered. Twenty-Four hours (24) notice is required for cancellation of a scheduled appointment time, otherwise a charge will be made for the time reserved.

Client's Signature