Confidential Client Information

Date: Referred by: Therapist:

Client Name Age: Date of Birth:

Home Address:

Home Phone: Work Phone: Other:

Insurance Company: Group#

Phone# Policy#

Social Security Number:

Occupation: Education Level:

Relationship Status: ☐ Married ☐ Partner ☐ Single ☐ Separated ☐ Divorced

Partner/Spouse Name: Age: Occupation:

Children's Names and Ages:

Were you raised by: ☐ both parents ☐ single parent ☐ relative ☐ other

Mother's Name: Age: Occupation:

Father's Name: Age: Occupation:

Sibling(s) (names and ages):

Why are you seeking counseling?

Do you or any of your family members or significant other have a history of: (Check all that apply)

Alcoholism☐ Drug Abuse (prescription and or street drugs)☐

Nervous Breakdown:☐ Prolonged illness:☐ Eating Disorders: ☐

Other: ☐ If you checked any of the boxes please explain:

Are you taking any medications? ☐ Yes ☐ No If yes, please list:

Medication name	Dosage	Reason for taking it

Do you have any significant physical problems? Yes☐ No ☐
If yes, please explain:

Have you had any previous psychiatric care or counseling? Yes ☐
No ☐
If yes, please explain:

Have you ever been hospitalized for a mental disorder, drug or alcohol problem? Yes☐ No ☐ If yes, please explain:

Have you, any of your family members or significant other attempted suicide?

Yes☐ No ☐ If yes, please explain:

Emergency Contact: Phone:

Relationship to you:

Client Signature Date