Client Information

Name: _____

Date Of Birth: _____ SS# _____

Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ Zip _____

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Employer _____ Position _____

Children or Step Children (Indicated by C or S)

Name	C or S	Age	Name	C or S	Age
_____	____	____	_____	____	____
_____	____	____	_____	____	____
_____	____	____	_____	____	____

Emergency Contact

Name _____

Relationship to Client _____

Phone Number _____

Health Insurance Coverage

Name of Insurance Company_____

Plan or Policy # _____

Individual ID # _____

Group # _____

Name of Insured if different from client _____

Referred By: _____

Previous Counseling (List Counselor's name(s) and approximate dates):_____

_____.

Results:_____.

Medication-List all medications you are currently taking.

1.) Name _____ Dosage_____
Prescribed for _____

2.) Name _____ Dosage_____
Prescribed for _____

3.) Name _____ Dosage _____
Prescribed for _____

4.) Name _____ Dosage _____
Prescribed for _____

Current Concerns and Goals- (List reasons for counseling at this time)

_____

_____

_____.

Indicate everything you have experienced during the last 6 months.

Use ✓ for Child X for_____ _____ for _____

- ☐ Loss of job
- ☐ Hospitalization
- ☐ Stopped smoking
- ☐ Pregnancy
- ☐ Retirement
- ☐ Alcohol or drug abuse
- ☐ Changes in memory or attention
- ☐ Panic or anxiety attacks
- ☐ Death of a close friend
- ☐ Death of a family member
- ☐ Self control problems(including anger)
- ☐ Weight loss or gain
- ☐ Increase number of arguments
- ☐ Nightmares
- ☐ Rape
- ☐ Flashbacks
- ☐ Depression
- ☐ Runaway
- ☐ Sibling conflict
- ☐ Anger Control
- ☐ Suicidal thoughts
- ☐ Sexual difficulties
- ☐ Traumatic event
- ☐ New family member
- ☐ Involved in a lawsuit
- ☐ Feelings of worthlessness
- ☐ Time management problems
- ☐ Financial difficulties
- ☐ Difficulty thinking clearly
- ☐ Authority issues
- ☐ Parent/ Adolescent conflict
- ☐ Verbal Abuse
- ☐ Physical abuse
- ☐ Decision making
- ☐ Marital/Partner conflict
- ☐ Major loss

- ☐ Grief
- ☐ Personal achievement
- ☐ Relationships with others
- ☐ Guilt / Shame
- ☐ Low self esteem
- ☐ Work related issues
- ☐ Divorce issues
- ☐ Problem solving
- ☐ Suicidal thoughts/attempts
- ☐ Inappropriate sexual behavior
- ☐ School Issue
- ☐ Parenting skill enhancement

Other_____

_____

_____.

_____ _____

Signature of person who completed form Date