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Client Information

Name:	DOB:
Address:	
If minor parent/guardian names:	
Contact Numbers	
Ноте	_ May a message be left?
Cell	_ May a message be left?
Work	May a message be left?
Email	
Who Can I Contact In An Emerge	ncy? (Name, Number, and Relationship)
Referred by	
	arch Therapist Directory Referral from provider
Referral from someone I kn	ow Attended a presentation Other
Occupation or School	

Confidential and privileged

Education
Married Domestic Partnership Single Divorced Widowed In a relationship
Do you have children? Ages
Are you currently under the care of a psychiatrist? If so may I contact him/her? Psychiatrist's name/phone number
Do you currently have any medical problems?
Please list all medications you are taking for either medical or mental health conditions
Please list medications you have taken in the past for psychiatric or emotional difficulties
Please briefly describe the problem or situation which led you to seek counseling today
Have you ever been in counseling before? If so when, and why?
Do you have any biological relatives with a history of emotional or psychiatric difficulties? If so who and what type of problem?

Please list members of your immediate family, your relationship, and their ages:
Do you ever drink alcohol? If so how frequently and when was the last time you had a drink?
Do you have a current or past history of using illicit drugs including prescription pain medications taken in a way in which they were not prescribed?
Do you have a current or past history of verbal or physical abuse by a domestic partner? Are you currently concerned about your personal safety?
What would you like to achieve in counseling and is there anything else important you'd like to tell me?