Client Information

Name: _____ Date of birth: ___/___/____

Address: _____ social security#___/___/____

_____

Ph #: ___-___-____ (day) OK to call? Yes/No OK to leave a message? Yes/No

Ph #: ___-___-____ (evening) OK to call? Yes/No OK to leave a message? Yes/No

Partner/spouse's name: _____Date of birth: ___/___/____

Emergency Contact Name:_____ Relationship to you_____

Address (if different): _____

Ph #: _____ (day) Primary Insured Name:_____

Ph #: _____(evening) Primary's ss# ___/___/___, DOB__/__/_____

Who referred you to this office?_____

Please list the names, ages, and relationships of all those in your current household: Date of Birth

Name: _____ Age: _____ Relationship: _____ / /

Name: _____ Age: _____ Relationship: _____ / /

Name: _____ Age: _____ Relationship: _____ / /

Name: _____ Age: _____ Relationship: _____ / /

Name: _____ Age: _____ Relationship: _____ / /

If you or your partner/spouse have children not living with you, please list their names, ages, and locations:

Name: _____ Age: _____ Location: _____

Name: _____ Age: _____ Location: _____

Name: _____ Age: _____ Location: _____

Occupation, employer, and current number of hours worked per week:

You: _____

_____

Partner/spouse: _____

_____

What health or medical problems do you or other family members have, and which medications are taken, if any?

Self/Family mbr: _____ Illness: _____ Medications: _____

Self/Family mbr: _____ Illness: _____ Medications: _____

Self/Family mbr: _____ Illness: _____ Medications: _____

Other Medical concerns: _____

_____

Who is your primary care physician? _____

Address: _____ Phone: _____

_____

Are you now or have you previously received substance abuse treatment? Yes/No Detox? Yes/No If so when/where/substances used? How long since last use?

When:	Where:	Substance used:	Last date used:
When:	Where:	Substance used:	Last date used:
When:	Where:	Substance used:	Last date used:
When:	Where:	Substance used:	Last date used:

Have you/your spouse or your children ever been a victim of or witness to physical/emotional/sexual abuse or domestic violence? Yes/No If yes, please explain:_____

_____

_____

_____

_____

Have you/your spouse or your children ever been a perpetrator of or accused of physical/emotional/sexual abuse or domestic violence? Yes/No If yes, please explain:_____

_____

_____

_____

_____

_____

_____

Are you or your children receiving any other type of therapeutic services either private or agency related (in-school services, Devereux, Department of Children and Families, AA/NA, etc.)? Yes/No If yes, please explain:

_____

_____

_____

_____

Have you or any family members ever received inpatient psychiatric services? If yes, please explain: (Circle)

Who:	When:	Where:	Voluntary/Involuntary	Length of stay:
Who:	When:	Where:	Voluntary/Involuntary	Length of stay:
Who:	When:	Where:	Voluntary/Involuntary	Length of stay:

Do you have any current or pending legal charges against you? Yes/No Any other legal matters I should be aware of? If yes, please explain:

_____

_____

_____

_____

What is the main issue for which you are seeking help?

How have you attempted to deal with this problem thus far (please be brief and specific)?

Have you had therapy or counseling before? Yes/No If yes, please list name, dates and location of provider(s):

Name: Date: Location:

Name: Date: Location:

Name: Date: Location:

If so, what was the nature of the therapy?

Was it helpful to you? Yes/No If not, briefly state why:

Please make any other comments here you wish, including critical events that have occurred in your family or anything unique about your family or other individuals which you think may be helpful for me to know prior to your first session:

Thank You