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Client Information

Please complete the following:

Today's Date ______________ Date of Birth_________________

Name: Last ______________________ First_________________
Home Address:____
City:____________________________ Zip Code:_____________
Phone:cell___________________home/work________________

Employer:____
Address:____
City:____________________________ Zip Code:______________

Spouse or family member to contact in emergency:
Name:____
Address:____
Phone Numbers:____

Referred by:____
Insurance Co. (if applicable):_______________________________

Current health status (circle): Fair Good Excellent
Date of last physical exam:_________________________________

Current health
problems:____
History of significant illnesses, health conditions, accidents, surgeries
etc:____
____
Physician:____

Current medications:_______________________________________
____
____

Do you smoke? __________ If so, how much____________________

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Do you drink caffeinated beverages?____ If so, how much________
Do you drink alcoholic beverages?__________ If so, what is your typical intake?______________________________________
Do you exercise regularly?__________ If so, please indicate the type and frequency of exercise__________________________________

Brief Description of reason for seeking therapy now:______________
____
____
____

Have you had previous therapy?
(circle): individual group couples none
Name of previous therapist(s)_______________________________
____
____

Please circle any areas in which you are having difficulty. Space has been allowed for you to include additional information.

Nervousness	Depression	Suicidal Thoughts
Shyness	Sexual problems	Finances
Divorce/separation	Boredom	Friends
Drug Use	Self-esteem	Unhappiness
Anger	Alcohol Use	Job performance
Sleep	Self-control	Dating skills
Relaxation	Stress	Assertiveness
Legal matters	Work pressure	Decision making
Energy	Headaches	Concentration
Loneliness	Memory	Health problems

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Relationships	Chronic pain	Marriage
Children	Career choices	Perfectionism
Bowel problems	Nightmares	Phobias
Irritability	Eating problems	Family problems
Disturbing thoughts	Parenting	Isolation
Anxiety	Fears	Panic attacks
Bereavement	Mood changes	Education

Other: