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**CLIENT INFORMATION**

This form requests information about you (or your child), which will be helpful in planning my services for you. Please take a few moments to complete the form carefully. I appreciate your time and effort in completing these documents.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip Code

Telephone: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Home

OK to contact there? Y N

Work

OK to contact there? Y N

Emergency Contact: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_

Name

Relationship to client

Phone number

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_

Relationship Status: \_\_\_ Single \_\_\_ Married \_\_\_ Partnership \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed

Spouse's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Please list all other persons living in your household, their ages and relationship to you:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Years Employed: \_\_\_\_\_

How were you referred to me? \_\_\_\_\_

**PRIMARY INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_

Insurance Company Contact Phone:

(\_\_\_\_\_) \_\_\_\_\_

Insured Name: \_\_\_\_\_

Insured SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_

Member #: \_\_\_\_\_

Policy/Group #: \_\_\_\_\_

Client's Relationship to the Insured:

\_\_\_ Self \_\_\_ Spouse \_\_\_ Dependent

**SECONDARY INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_

Insurance Company Contact Phone:

(\_\_\_\_\_) \_\_\_\_\_

Insured Name: \_\_\_\_\_

Insured SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_

Member #: \_\_\_\_\_

Policy/Group #: \_\_\_\_\_

Client's Relationship to the Insured:

\_\_\_ Self \_\_\_ Spouse \_\_\_ Dependent

## MEDICAL INFORMATION

When were you last examined by a physician? \_\_\_\_\_

Name of your Primary Care Physician: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
Street City State Zip Code

May I contact your physician if necessary? Yes / No \_\_\_\_\_  
*Please Initial*

List any major health problems for which you currently receive treatment:  
 \_\_\_\_\_  
 \_\_\_\_\_

List any medications you are now taking:

Medication Name:	Date Began:	Current Dose:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe your reason(s) for seeking treatment at this time. Include when the problem started: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever received mental health or substance abuse treatment of any kind before? Yes / No

Provider Name	Reason for seeking help	First Seen	Last Seen
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### PROBLEM LIST

Please indicate past problems with a "P" and current problems with a "C".

- |                              |                                |   |
|------------------------------|--------------------------------|---|
| _____ Depression             | _____ Chronic Illness          | _____ Marriage/Relationship Issues                                |
| _____ Anxiety                | _____ Chronic Pain             | _____ Sexuality/Sexual Issues                                     |
| _____ Stress                 | _____ Loneliness               | _____ Family Conflict   |
| _____ Grief/Loss             | _____ Eating or Weight Problem | _____ Behavioral Problems   |
| _____ LD/ADHD                | _____ Abuse/Victimization      | _____ Schizophrenia/Psychosis                                     |
| _____ Anger                  | _____ Domestic Violence        | _____ Phobias/Fears   |
| _____ Obsessions/Compulsions | _____ Manic Episodes           | _____ Eliminating a drug/alcohol habit                            |
| _____ Trauma                 | _____ Legal Matters            | _____ Eliminating another habit<br>(i.e., overspending, gambling) |

Please indicate how the problems are affecting the following areas of your life:

	<u>No Effect</u>	<u>Little Effect</u>	<u>Some Effect</u>	<u>Much Effect</u>	<u>Significant Effect</u>	<u>Not Applicable</u>
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A

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