Personal Information

_____ _____ _____ ___ ___
Last Name First Name Initial Birth Date Age F M

Address_____

City/Zip_____

Marital Status: Single ___ Separated ___ Married ___ Divorced ___ Widowed ___

Phone #: H_____W_____C_____

O.K. to leave messages at: H___ W___ C___

Employer_____ Occupation_____

Work Address: _____

Family Information

Spouses name_____
(If minor, name of parent)

Spouses Employer_____ Phone#:_____
(If minor, parent's employer)

Dependents: Name Age Gender Relationship
(If minor, siblings)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

In case of an emergency notify:_____ Relationship_____

Address:_____ Phone_____

Person responsible for this account_____ Relationship_____

Address_____ Phone #:_____

Referred by: _____

May I thank the person who referred you? Yes____ No____

Client Information Questionnaire

What is the name, address, and phone number of your physician: _____

_____

Date last examined by physician: _____

List all medications you are now taking: (*If additional space is needed, please write on backside of this page and indicate that you have done so)*

Medication	Dose	Frequency	Purpose of Medication
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name, address and phone number of doctor(s) prescribing medications if different from above. Please include doctor's specialty: _____

_____

Have you ever been hospitalized? _____ If yes, please give approx. dates and reasons:

_____

_____

Have you ever received counseling before? _____ If yes, when, with whom and for what purpose?

_____

_____

Are you presently receiving counseling? _____ If yes, with whom and for what?

_____

Has anyone in your family history been treated for a psychological and/or drug/alcohol problem? _____
If yes, specify who and what they were treated for. _____

_____

_____

Is there anyone in your family who has or has had a psychological and/or drug/alcohol problem for which they have **not** had treatment? _____ If yes, please specify:

_____

_____

In your own words, please describe the problems that brought you to counseling:

_____

_____

_____

Please Circle Any of The Problems Which Pertain to You:

Anxiety	Self-Harm	Insomnia	Work
Shyness	Children	Inferiority Feelings	Tiredness
Separation	Bowel Troubles	Career Choices	Ambition
Drug Use	Depression	Nightmares	Making Decisions
Anger	Sexual Problems	Appetite	Concentration
Body Image	Divorce	Being A Parent	Health Problems
Relaxation	Alcohol Use	Fears	Marriage
Legal Matters	Self-Control	Suicidal Thoughts	Stomach Trouble
Energy	Stress	Finances	My Thoughts
Loneliness	Headaches	Friends	Relationships
Education	Memory	Unhappiness	Trauma
Physical Abuse	Sexual Abuse		