CLIENT INFORMATION FORM

Name:_____

Home Phone:_____ Cell Phone:_____

Home Address:_____

City, State & Zip Code:_____

Date of Birth:_____

Marital Status: Single Living Together Married Separated Divorced Widowed

How Many Years:_____ Partner's Name:_____

Name & Ages of Children:_____

Name of Employer/Town Located: _____

Job Title:_____

Payment Type ***(Circle One)***: Insurance EAP Cash

Is there a secondary insurance plan?_____ If Yes, Name:_____

Emergency Contact Name & Phone Number:_____

Physician Name & Phone Number:_____

(No contact will be made without a signed released, unless it is a medical and/or psychiatric emergency.)

Reason for initial visit:_____

(OVER)

Have you had counseling before?_____ If yes, when?_____

Reason?_____

Have you ever been psychiatrically hospitalized?_____ How Many Times?_____

If yes, where and when:_____

Reason for hospitalization?_____

Current medications ***(medical & psychiatric)***:_____

_____

Do you use alcohol and/or street drugs?_____

If yes, type? Quantity? Frequency?_____

_____

Have you ever had treatment for use of alcohol and/or street drugs?_____

If yes, where and when?_____

_____

What are your personal goals?_____

_____

Do you have hobbies?_____ If yes, what?_____

Referred by:_____