# CLIENT INFORMATION FORM

Name:_____

Home Phone:_____ Cell Phone:_____

Home Address:_____

City, State & Zip Code:_____

Date of Birth:_____

Email address: _____

Marital Status: Single Living Together Engaged Married Separated Divorced Widowed

How Many Years (if in a relationship):_____ Partner's Name:_____

Name & Ages of Children:_____

Name of Employer and Job Title: _____

Military service, branch, and years served _____

Payment Type ***(Circle One)***: Insurance EAP Self-Pay

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

Covered individual _____ Their birthdate _____

Emergency Contact Name, Relationship & 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 counseling appointment:_____

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

Why?_____

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

If yes, when and where?_____

_____

Reason for hospitalization (s)?_____

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

_____

Do you use alcohol and/or street drugs? If yes, type, quantity, and 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:_____