



Confidential Client Information

Name: _____ Date _____

Address: _____ Date of Birth/Age _____

City, State, Zip: _____ Social Security Number _____

Policyholder Name: _____ Home Telephone # _____

Insurance Carrier _____ Policy/Group #/ _____ Cell/Work Telephone # _____

Policyholder DOB: _____ Policyholder SS#: _____ Email Address _____

Phone Number to Verify Benefits: _____

Address to Mail Claims: _____

Employer's Name and Address: _____

Current Marital Status: _____ Date Married: _____ Age at Marriage: _____

Dates of any previous marriages: _____

Name, Age, & Sex of Children (include those of your spouse, those from previous marriages, and any deceased):

Highest educational level attained : _____

Current employment: _____

List any major illnesses and injuries you have had in the past: _____

List any medications you take: _____

List any surgeries or hospitalizations you have had in the past: _____

List any allergies to any medications: _____

Are you currently under a doctor's care for any physical condition? _____
Physical condition? _____

Name and telephone number of your Doctor: _____

May I contact your Doctor to coordinate care if necessary Yes [] No []

If Yes, Please Sign Here for Authorization _____

Do you smoke? Yes/No If yes, how many packs per day? _____

Do you drink alcohol? Yes/No If yes, how many glasses per day? _____

Do you use other drugs Yes/No If yes, what? How frequently? _____

Previous counseling or therapeutic help: _____

From whom? _____ Dates: _____

Was counseling beneficial? _____ Why or Why not? _____

Briefly state why you are seeking therapy and your goals for therapy: _____

How long has this situation been in existence? _____

Please circle all of the following that apply:

- | | | | |
|----------------------------|------------------------|------------------------|-------------------|
| Abuse/Neglect | Family Conflict | Panic | Stress |
| Anger | Financial Difficulties | Parenting Difficulties | Suicidal Thoughts |
| Anxiety/Nervousness/Fears | Grief/Loss | Life Transition | Abortion |
| Health Problems | Promiscuity | Tiredness | Transitions |
| Career/Work Difficulties | Irritability | Psychosis | Trauma History |
| Concentration Difficulties | Legal History | Poor Self Control | Weight Loss/Gain |
| Depression | Loneliness | Relationship Issues | Drugs/Alcohol |
| Divorce/Separation | Low Self Esteem | Sexual Problems/Issues | Nightmares |
| Eating Disorder/Problems | Memory Difficulty | Social Skills Deficits | Sleep Difficulty |
| Domestic Violence | _____ | _____ | _____ |

