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CLIENT INFORMATION

Name: _____

Address: _____

City: _____ Zip: _____

Telephone _____ _____ _____
Home Cell Work

Age: _____ Date of Birth: _____

Referred by:

□ Colleague □ Current/Former client □ EAP provider □ Friend/Family

□ Victim Witness □ Website/Internet □ Other: _____

EMERGENCY CONTACT: _____ _____(phone)

CURRENT LIVING SITUATION:

Name of spouse or partner: _____ Age: _____

Name of Children: _____ Age: _____

_____ Age: _____

_____ Age: _____

_____ Age: _____

MEDICAL:

Current medical provider: _____

Current medical issues/concerns: _____

_____

Current medications (for psychological or medical reasons):

Current medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous therapy or mental health treatment:

Name of therapist or provider	Dates of services (approximate month/year)
_____	_____
_____	_____
_____	_____

CURRENT SITUATION:

Presenting problem (brief history of problem, when it first occurred, prior attempts to a solution):

_____

_____

_____

_____

_____

_____

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