Date: _____

CLIENT INFORMATION:

Identification:
Name: _____
Phone: (Hm)_____(Cell)_____(Wk)_____
Address: _____ City: _____ Zip: _____
Sex: M___ F___ Marital Status: _____ Date of Birth: _____
Others living at home: _____

Employment/Education:
Employer: _____ Position: _____
How long have you worked at this job? _____
Highest level of education attained: _____ Year: _____

Health:
Primary physician: _____ Phone: _____
List any significant health problems:
_____
_____
List any medications you are presently taking & the dosage:
_____
_____
_____
Do you smoke? Yes____ No____
Do you drink? Yes____ No____
Are you now, or have you ever been in therapy? Yes____ No____
If yes, date(s) of service: _____
Name of therapist(s): _____
Brief description of issues worked on: _____
_____
_____

Chief Concern: Describe the main difficulty that has brought you to see me:
_____
_____
_____

Referral/Contact:
Referred by: _____
Where may I contact you if necessary_____
May I contact you by email? _____ Email address: _____
Address if different from above:_____Phone:_____
Emergency contact name: _____ Phone: _____

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