

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: \_\_\_\_\_