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CLIENT INFORMATION

This form requests information about you (or your child), which will be helpful in planning my services for you. Please take a few moments to complete the form carefully. I appreciate your time and effort in completing these documents.

Name: _____ Today's Date: _____

Address: _____
Street

_____
City State Zip Code

Telephone: (_____)_____ (_____)_____
Home OK to contact there? Y N Work OK to contact there? Y N

Emergency Contact: _____ (_____)_____
Name Relationship to client Phone number

Age: _____ Birth Date: _____ SSN: _____

Relationship Status: ____ Single ____Married ____ Partnership ____Separated ____Divorced ____Widowed

Spouse's Name: _____ Age: _____ Occupation: _____

Please list all other persons living in your household, their ages and relationship to you:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Education: _____ Occupation: _____

Place of Employment: _____ Years Employed: _____
How were you referred to me? _____

PRIMARY INSURANCE INFORMATION
Insurance Company: _____
Insurance Company Contact Phone:
(_____)_____
Insured Name: _____
Insured SSN: _____ DOB: _____
Employer: _____
Member #: _____
Policy/Group #: _____
Client's Relationship to the Insured:
____ Self ____Spouse ____ Dependent

SECONDARY INSURANCE INFORMATION
Insurance Company: _____
Insurance Company Contact Phone:
(_____)_____
Insured Name: _____
Insured SSN: _____ DOB: _____
Employer: _____
Member #: _____
Policy/Group #: _____
Client's Relationship to the Insured:
____ Self ____Spouse ____Dependent

MEDICAL INFORMATION

When were you last examined by a physician? _____

Name of your Primary Care Physician: _____

Physician's Address: _____
Street City State Zip Code

May I contact your physician if necessary? Yes / No _____
Please Initial

List any major health problems for which you currently receive treatment:
_____
_____

List any medications you are now taking:

Medication Name:	Date Began:	Current Dose:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe your reason(s) for seeking treatment at this time. Include when the problem started: _____
_____
_____

Have you ever received mental health or substance abuse treatment of any kind before? Yes / No

Provider Name	Reason for seeking help	First Seen	Last Seen
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PROBLEM LIST

Please indicate past problems with a "P" and current problems with a "C".

_____ Depression	_____ Chronic Illness	_____ Marriage/Relationship Issues
_____ Anxiety	_____ Chronic Pain	_____ Sexuality/Sexual Issues
_____ Stress	_____ Loneliness	_____ Family Conflict
_____ Grief/Loss	_____ Eating or Weight Problem	_____ Behavioral Problems
_____ LD/ADHD	_____ Abuse/Victimization	_____ Schizophrenia/Psychosis
_____ Anger	_____ Domestic Violence	_____ Phobias/Fears
_____ Obsessions/Compulsions	_____ Manic Episodes	_____ Eliminating a drug/alcohol habit
_____ Trauma	_____ Legal Matters	_____ Eliminating another habit (i.e., overspending, gambling)

Please indicate how the problems are affecting the following areas of your life:

	No Effect	**Little Effect**	**Some Effect**	**Much Effect**	**Significant Effect**	**Not Applicable**
Marriage/Relationship	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School Performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Financial Situation	1	2	3	4	5	N/A
Physical Health	1	2	3	4	5	N/A