Client Information Form

Client Name: _____ **Date:** _____
Date of Birth: _____ **SSN:** _____
Address: _____
City/State: _____ **Zip Code:** _____
Home/Cell Phone _____ **Work Phone** _____
Email: _____ **Confirm appointments?** ☐ **Yes** ☐ **No**

Emergency Information:
Emergency Contact: _____ **Phone:** _____
Relationship to Client: _____

Employer/School (if student): _____
Insurance Company _____ **Insurance Phone:** _____
Policy Holder Name: _____
Policy ID: _____ **Group:** _____
Claims Address: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Family/Household Members:

Name:	Relationship:	Age:	In Household:
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

What concern brings you to counseling?

_____
_____
_____
_____

What changes do you want to see as a result of counseling?

_____
_____
_____
_____
_____

Referral Source: _____

Medical History:

Name of your Primary Care Physician: _____
Address: _____

_____

Phone Number: _____ **Fax:** _____

Are you currently under doctor's care? ☐ **Yes** ☐ **No**
Doctor(s) involved in your care: _____
Date of last Physical Exam or last time seen _____

Health Issues:

Medications currently using: (if none, please state none)

Medication:	**Dosage:**	**Doctor Prescribing:**	**Reason Prescribed:**

Do you have any allergies to medications or foods? ☐ **Yes** ☐ **No**
If yes, what allergies and what type of reactions: _____

Past Hospitalizations - Medical, Psychiatric, Chemical Dependency:

Date	**Reason**	**Hospital**

Past Psychiatric Treatment (Mental health and Chemical Dependency):

Dates of treatment:	**Previous Providers**	**Type of Care**	**Response to Care**

Additional Information or Comments: