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Client Information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Can I contact you at this email address? Yes/No

Home Phone: _____ Can messages be left at this number? Yes / No

Cell Phone: _____ Can messages be left at this number? Yes / No

Date of Birth: _____ Last 4 digits of your social security number: _____

Children:

Name	M/F	Age	Mother/Father's Name

Relationship Status (Single, Married, Life Partner, Dating, or Other) : _____

Emergency Contact Person: _____ Phone: _____

Relationship of Emergency Contact: _____

Have you attended counseling in the past? If yes, where and when? _____

Financial Responsibility:

Who is financially responsible for services? _____

Insurance Company: _____

Insurance Company Address: _____

Policy Holder's Name: _____

Policy Holder's Social Security #: _____ Policy Holder's Date of Birth: _____

Policy Number: _____ Group Number: _____

Policy Holder's Employer: _____ Work Phone Number: _____

Family History:

	Living?	Age or Age at Death	Present Health/Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Do you have any family history of mental illness? (Bipolar, Schizophrenia, Depression, Substance Abuse, etc.) Yes / No

If you answered yes to the above question please provide additional information below:

Medical History:

Family Physician: _____ Phone Number: _____

Date of last physical: _____ Date of last hospitalization: _____

Please list any medications (prescription or nonprescription) that you are currently taking:

Do you use tobacco? Yes / No If yes how much? _____

Do you use alcohol? Yes / No If yes how much? _____

Do you use any other substances such as marijuana, cocaine, amphetamines, etc.?

Yes / No If yes how much and how frequent? _____

Please circle any of the following symptoms/conditions that you experience:

Headaches	Heart Trouble	Thoughts of Self Harm
Dizziness	Irritability	Depression
Head Injury	See or Hear things that are not there	Diabetes
Thyroid Problems	Weight gain or loss	Anemia
Fatigue		Anxiety
Feel Out of Control	Difficulty sleeping	

Please list/describe any other medical disease/condition that you may have or experience that is not mentioned above:

Do you have any history of emotional, physical, or sexual abuse? If so please describe below:

Other:

What are your reasons for seeking counseling/parenting services at this time?

Is there anything else you would like to share that was not asked above?
