

CLIENT INFORMATION

Instructions: Please complete all of the following questions accurately. This information will be helpful in serving your needs. This information is confidential (see confidentiality on disclosure statement)

Today's date_____

Name_____

Address_____

(street)

(city)

(zip)

Phone (home)_____ (work)_____

Date of birth_____

FAMILY-RESIDENCE

Please give name of current spouse/significant other and length of relationship:

_____ Previous marriages? _____

Currently living with: alone spouse Significant other housemates
(Circle all that apply) children siblings parent(s)

Family members (Name)	AGE	Rate the relationship 1-10 (1 poor, 10 very good)
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Mother/wife

Father/husband

Child/siblings 1

Child/sibling 2

Child/sibling 3

Child/sibling 4

Important others

What is your birth order? Only Oldest Middle Youngest
Were you raised with both parents? Y N If no please explain:

Any other family information that is significant? _____

MEDICAL-HEALTH INFORMATION

Primary Physician: _____

When was your last visit _____?

Health concerns now or in the last 12 months _____

List all medications you are taking or have taken in the past month _____

Any other important medical-health information _____

Mental Health-Emotional- Behavioral Information

Do you have concerns regarding your behavior or someone else's in any of the following areas: If it is someone else please indicate who/relationship:

Alcohol	Y/N _____	Depression	Y/N _____
Drugs	Y/N _____	Anxiety/Nervousness	Y/N _____
Eating disorder	Y/N _____	Sexual relationship	Y/N _____
Gambling	Y/N _____	Communicating	Y/N _____
Sexual acting out	Y/N _____	Anger	Y/N _____
Physical abuse	Y/N _____	Difficulty setting limits	Y/N _____
Verbal abuse	Y/N _____	Parenting	Y/N _____

Do you consume alcohol Y/N_____ How much per day ? _____ Has anyone ever complained about your drinking? Y/N _____ Who _____

Have you or anyone in your family been treated for alcohol, drug, or other mental health issues?

If yes: Who _____Relationship _____

For what _____Where and when _____

Have you or anyone in your family ever attempted suicide Y/N If yes who? _____

Have you had suicidal thoughts recently Y/N Please explain_____

Do you smoke? Y/N _____ # per day_____ per week _____.

Do you get regular exercise Y/N ___ If yes please describe _____

How satisfied are you with your life in general 1 not at all, 10 very much _____

Please list your strengths: _____

THERAPY

Who referred you for therapy? _____

Why are you coming for therapy? _____

What have you done to address the problem_____

What are your goals for therapy ? _____

How would you know you were achieving those goals ? _____

Are you involved in any legal/disciplinary action right now Y/N _____ If yes, is that why you came to therapy? Y/N If yes please explain _____

Please rate your level of willingness to work on this/these issue(s) 1 not at all -10 very

_____ Please comment on how you rated yourself _____

Anything else you would like me to know._____
