

CLIENT INFORMATION FORM

(PLEASE FILL OUT, PRINT AND RETURN)

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NAME			DATE OF BIRTH	GENDER
ADDRESS			MARITAL STATUS	
CITY	ZIP CODE		EMERGENCY CONTACT	PERSON
TELEPHONE	HOME CELL		TELEPHONE NUMBER	
	Y HISTORY our relationship during childhood with:			
Mother:			Siblings:	
mounor.			NAME	AGE
Father:			Children:	
			NAME	AGE
	IONSHIPS past marriages or significant partners:			
NAME		MARRIED	COHABITING	LENGTH OF RELATIONSHIP
NAME		MARRIED	COHABITING	LENGTH OF RELATIONSHIP
NAME		MARRIED	COHABITING	LENGTH OF RELATIONSHIP
Are you cur	rrently experiencing any of the followin	g? Domestic Violence	e Emotional Abuse	Sexual Abuse Threats

EMPLOYMENT			EDUCATION				
JOB TITLE Are you satisfied with your position? Are you experiencing financial problems?		No No	Are you currently in school? Do you plan to return? Last grade completed?	Yes Yes	No No		
LEGAL							
Do you have any past or present legal is:	sues? Yes	No	Have you ever been arrested?	Yes	No		
If yes, please explain			If yes, please explain				
SOCIAL HISTORY							
Describe your social network:		How do you spend your free time?					
			Hobbies:				
DEVELOPMENTAL							
During your childhood and/or adolescenc	e, did you expe	rience any of th	ne following?				
Hospitalizations Sleep problems	School problen Feeling self-co Vision problem Physical Abuse	nscious Is	Hearing problems Sexual Abuse Speech problems Mental/Emotional Abuse	Hyperactivity Suicidal thoughts/Attempts			
Do you have any past or present concerns	s related to sex	ual orientation	? Yes No				
RELIGIOUS/SPIRITUAL E	BACKGRO	UND					
Do you have any religious or spiritual conflicts or concerns?	Yes	No	Do you practice a certain fair	th or belief?			
If yes, please explain							

MEDICA	L						•			
Do you have	any medical cond	ition/s?				Are you taking any medications?				
					_					
Do you have	any allergies?					Medications taken in the past?				
					_					
	to any medications				_					
					_					
SUBSTA	NCE ABUSE	HISTOR	Υ			Do you consume alcohol or other substances now?	Yes	No		
	history of substance	e abuse?	Yes	No		If so, how often?				
If so, what sul	ostances?					How much do you drink or use at one time?				
						Date of last use				
PAST OF	PRESENT C	OUNSE	LING							
DATE		LOCATIO	N			What brings you to counseling at this time?				
DATE		LOCATIO	N							
DATE		LOCATIO	N			What would you like to get out of counseling?				
	been hospitalized for substance abuse		Yes	No		what would you like to get out of couliseinig:				
Do you curren homicidal thou	tly have suicidal or ughts?		Yes	No						
HOW DI	D YOU HEAR	ABOUT	THE	RELATI	IONSH	IP CENTER?				
Internet	Direct Referral	Mailing	Other							
THERAPIST SIG	NATURE					DATE				