

Client Information	
Name	Date
Home Phone	Mobile Phone
Work Phone	
May I contact you? (Please circle one) Yes or No	If so, which number is best?
May I leave a message? (Please circle one) Yes or No	
Fax Number	
Email Address	
Street Address	
City, State, Zip Code	Birthdate
Job Information	
Name of Company	Job Title
How long have you worked there?	
Any job related concerns?	
What is the reason for your visit?	
Family History	
Marital Status: Single Married/Partnered Separated Divorced Widowed Other_____	
Partner's Name & General Description of Relationship	
Parent's Name	
Sibling/s Name	
Child or Children Name/s	

Persons Living in Household			
Name	Sex	Age	Relationship
Education and/or employment			
Emergency Contact's Name		Phone	
Relationship		Address	
Environmental Stressors			
Marriage/Relationship		Divorce/Break-up	
Employment		Family	
Illness		Legal	
Other current stressful situations			
Drug & Alcohol Use	Frequency/Amount		First Use/Last Use
Mental Health History			
Therapy Dates		Hospitalization / Medication	
Therapist (License Type)			
Agency			
Contact Information			
Tests Given			
Therapy Dates		Hospitalization / Medication	
Therapist (License Type)			

Agency		
Contact Information		
Tests Given		
Medical History		
Currently being treated for a medical problem?		Yes No
Doctor	Condition	
Doctor	Condition	
Doctor	Condition	
Current Medications		
Medication	Dosage/Frequency	Prescribed by
Date of last physical exam	Results	
Any other relevant medical history?		
Anything else you think I should know?		

Thank you for taking the time to answer these questions.