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**CONFIDENTIAL CLIENT INFORMATION**

Client Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

May I call you: at home? Y N on your cell? Y N at your work? Y N

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_\_ Children \_\_\_\_\_

**In Case of Emergency**

Notify \_\_\_\_\_ Relationship \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

**Presenting Problems:**

Please describe your reasons for seeking therapy:

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**Family History:**

Describe any relevant emotional, medical or chemical dependency issues of your parents/family:

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**Psychiatric History:**

Have you ever received psychiatric or psychological treatment before? Y      N

If you answered "yes" to the above question, please answer the following:

What type of care did you receive?      Inpatient (hospital)      Outpatient      Both

Were you prescribed medications at that time? Y      N

If "yes," what was prescribed?

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**Substance Use History:**

Have you ever abused drugs or alcohol? Y      N

If "yes," please specify:

Substances	Amount	Frequency	When?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever received substance abuse treatment of any kind before? Y      N

**Habits:**

**Amount Currently Using**

**Most Ever Used**

Coffee (cups/day)	_____	_____
Cigarettes (packs/day)	_____	_____
Alcohol (drinks/day)	_____	_____

**Please rate from 0 – 10 how your problems are affecting you in the following areas:**

Relationship\_\_\_\_\_ Family\_\_\_\_\_ Job/School\_\_\_\_\_ Friendships\_\_\_\_\_

Hobbies\_\_\_\_\_ Finances\_\_\_\_\_ Physical Health\_\_\_\_\_ Anxiety level\_\_\_\_\_

Mood\_\_\_\_\_ Eating Habits\_\_\_\_\_ If your eating habits are affected, describe how:

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Sexual Functioning \_\_\_\_\_ Concentration \_\_\_\_\_ Ability to Control Temper\_\_\_\_\_

Sleeping Habits \_\_\_\_\_ If your sleeping habits are affected, describe how:

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