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CLIENT INFORMATION ***(Person for whom services are being sought)***

______________________________ ________ ________________________________
Client First Name M.I. Last Name

______________________________ ______________________ _____/_____/_______
Maiden Name (if applicable) Social Security Number Date of Birth

☐ Male ☐ Female Age:_______ Race:_______________________

____
Address City Zip Code

Home Phone #:____________________ Other Phone #:______________________

Place of Employment (if applicable): ______________________ Phone:____________________

School Attending (if applicable):_____________________________________ Grade:__________

EMERGENCY CONTACT ***(If client is under 18, please list legal guardian)***

____________________________________ ____
First Name Last Name

____
Address City Zip Code

Emergency contact number______________________________Relationship:_____________________

Insurance Co.: ____ Policy #: _______________________

Group #: ______________________________ CoPay Amt.(If known) $_________________________

If client is under 18, please complete

With whom does client live? ____

Does client have visitation with the other parent? If so, _______________________________________
Parent's Name

____ ____________________________

Parent's Address Phone Number

Who is/are the legal guardian(s)? ____

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CONTACT INFORMATION

Please indicate the number at which you prefer to be contacted: ______________________

Is it okay to leave a voicemail at this number? Yes _______ No __________

May I leave a message with anyone who answers at this number? Yes ________ No __________

Alternate Number(s): ______________________ OK to leave messages here? Y N

HEALTH HISTORY

____

Primary Care Physician Phone Number

____

Address City Zip Code

Does Client have any past or significant Medical Problems and/or Diagnosis? ☐Yes ☐No

If yes, please describe: ____

____

____

Is client currently taking any medications? ☐Yes ☐No If yes, list medicine and dosage.

____

____

Does client have any allergies or adverse reactions? ____________________________

____

WHO REFERRED YOU? (How did you find us?) ____________________________

REFERRAL REASON *(Please check all that apply):* ☐Suicide Issues ☐Sexual Abuse

☐ Physical Abuse ☐Domestic Violence ☐Home/Family problems ☐Marital ☐Divorce

☐ Death of a family member ☐Death of a friend ☐ Law Violation ☐Depression

☐ Employment Problems ☐Anger Management ☐Severe Injury/Accident ☐Anxiety

☐ Drug/Alcohol Problems by Client ☐ Drug/Alcohol Problems by Significant Other

☐ Other Reason *(describe)*________________________

I WOULD LIKE TO WORK ON: ____

____

Client Name:______________________________ **CONFIDENTIAL**