

CLIENT INFORMATION SHEET

Name _____

Current Address _____

Permanent Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____

Is it ok for me to leave messages for you at: HOME.....WORK.....CELL.....?
(please circle those that are ok)

Birthdate _____ Age _____ Social Security # _____

Emergency Contact Person _____
(name and phone)

INSURANCE INFORMATION (strike out if not applicable)

Name of your Health Insurance Company _____

Your ID# _____ Please provide a copy of your insurance care to complete information

Assignment of Benefits: I hereby authorize the above insurance company to make payment directly to the provider for the benefits herein and otherwise payable to me. I authorize the release of any medical information necessary to process my insurance claims.

Client's Signature

Date

Please continue...



ABOUT YOU...

Gender: Female Male Transgender Other: _____

Living Situation: Alone Roommate Partner Family

Relationship Status: Single Partnered (name _____) Dating

Employed as: _____ Are you a student? N Y at: _____

Do you have children? N Y Names & ages: _____

Name of your family doctor: _____

List any chronic medical conditions: _____

List any medications, vitamins or supplements that you take: _____

Frequency and quantity of alcohol: _____ drinks, _____ time(s) per week/month (circle one)

Frequency and type of other drugs: _____

Have you ever gone to counseling before? N Y

Have you ever been the victim of abuse? N Y Maybe

Are you having thoughts of harming or killing yourself? N Y

Check all that have applied to you in the past month. Put two checks for those items that have bothered you most:

- | | | |
|---|--|--|
| <input type="checkbox"/> Sad mood | <input type="checkbox"/> Worry | <input type="checkbox"/> Too much energy |
| <input type="checkbox"/> Thoughts of worthlessness | <input type="checkbox"/> Frequent crying | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Fear | <input type="checkbox"/> Anger problems |
| <input type="checkbox"/> Low energy | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Eating problems |
| <input type="checkbox"/> Loss of interest in things | <input type="checkbox"/> Shakiness | <input type="checkbox"/> Loss of control |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> Shame | <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Work/school problems |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Hard time concentrating | <input type="checkbox"/> Parenting problems |

In your own words, what brought you in today? _____
