Client Information Sheet

Date: ____________________ Referred by: ____

Name: ____

Address: ____

City, State, and Zip Code____

Home and Cell phone: ____

Work Phone: ______________________________ Date of Birth: __________________________________

Social Security Number: ___________________ Name of Insured: _________________________________

Date of Birth of Insured: ___________________ SSN of Insured: __________________________________

Insurance Co. & Group ID #____

Occupation: _____________________________________ Employer: _________________________________

Occupation of Insured: ___________________________ Employer of Insured: _________________________

Email Address: ____

Family Information

Name of Spouse: ____ Age: ______________________

Address: ____ Phone & Cell: ___________________________

Closest Relative not Living with you: ____

Phone and/or cell number: ____

Names and ages of minor children and where they reside: ____

____

Medical Information

HIPPA Regulations Apply

What medications are you taking? ____

Who is your primary care physician? ____

Last Medical Exam? ______________________ Previous Hospitalizations __________ # ___________________

If yes, when: ___________ Any current medical problems? _______________________________________

Have you ever been to a counselor? If so, who & when?____

What was accomplished?____

What is happening in your life which resulted in this appointment? ______________________________

____

What would you like to accomplish in therapy? ____

____

Chief Complaint (check all that apply)

__Depression
__Low energy
__Low self-esteem
__Sleeping too much
__Hopelessness
__Worthlessness
__Guilt
__Sleeping too little
__Obsessions
__Thoughts of hurting yourself
__Thoughts of hurting others
__Sadness/Loss/Grief
__Anxiety/Pain
__Heart pounding/racing
__Chest Pain
__Sweating
__Chills/Hot Flashes

__Fear of Dying
__Nausea
__Fears/Phobias
__ Compulsions
__Thoughts racing
__Feeling of unreality
__Anger/Frustration
__Headaches
__Argues
__Blames others
__Excessive use of drugs/or alcohol
__Excessive use of prescription medication
__Physical Abuse issues
__Sexual Abuse issues
__Lack of appetite

__Intrusive Thoughts
__Loneliness
__Fatigue
__Difficulty concentrating
__Marital/Family problems
__Poor impulse control
__Difficulty trusting
__Excessive gambling
__Confusion
__Pain
__Relationship Problems
__Flashbacks
__Sexual problems
__Trouble relaxing
__Eating related problems
__Tingling/Numbness
__Other issues