Client Information

Today's date:____________

A. Identification:

Your full name:______________________________

Date of birth: ____________ Age:____________

Social Security number:______________________

Home street address:____

City:____________State:____________ Zip:____________

Phone (Cell):__________________ (Home):________________(Email)________________

Calls will be discreet, but please indicate any restrictions:____

B. Referral:

Who gave you my name to call?______________________

Name:_______________________ Phone:______________________

How did this person explain how I might be of help to you?____

May I have your permission to thank this person for the referral? __ Yes __ No

C . Your Medical Care:

From whom or where do you get your medical care?____

Clinic/doctor's name: ______________________ Phone: ______________________

Address: ____

Medications: ____

Past or current health issues: ____

Major medical surgeries: ____

D. Emergency Contact: ____

Telephone: ______________________________________

E. Education:

Highest level of education?________________________

Where did you graduate from?________________________

Date graduated: ____________________

F. Employment

Are you currently employed? __ Yes __ No

If so, where are you currently employed?____________________________

How long?_____________

Address:____

Work phone:_____________________________________

Calls will be discreet, but please indicate any restrictions:____
____

G. Relationships & Family:

I identify as: ___ Heterosexual ___ Homosexual ___ Bisexual

Are you in a relationship? __ Yes __ No

If so, how long have you been in this relationship ______________________________

Are you currently married or have you ever been married? __ Yes __ No

If so, how long have you been married? ______________________________

Do you have any children? __ Yes __ No

If so, please provide their name(s) and include their age(s):
____
____

Are your parents still alive? __ Yes __ No

If so, please provide their ages and include any information about their current health status. If your parent(s) are deceased, please provide the year and cause of death.

____
____
____

Is there a history of depression, anxiety, addiction or suicide in your family? __Yes__No

If so, please explain:
____
____
____

Do you currently or have you ever had a history of dependency/abusing alcohol or drugs (prescription or illegal)? __ Yes __ No

If so, please provide more information including dates, frequency and type of substance(s):

____
____
____

Do you or have you ever had suicidal thoughts? __ Yes __ No

Have you ever tried to commit suicide? __ Yes __ No

If so, please provide more information including dates, treating providers and/or hospitalizations:

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____