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Client Information

Name: ____

Address: (Street & Number) ____________________________________

City, State, Zip: ____

Telephone: _____________________ Work/Cell: __________________

Can I leave a message at the above numbers? ____ yes _____ no

Email address: ____

Age ______ Date of Birth: _________Highest Educational Level: ________

Previous Mental Health Service: _____ yes _____ no

How would you describe your general health at this time?

____excellent _____ good _______ fair _____ poor

Are you currently being treated for any medical condition? ____yes ____no

Explain: ____

Name and phone number of Doctor:

____

NOTE: NO CONTACT WILL BE MADE WITHOUT YOUR WRITTEN CONSENT TO DO SO

Are you taking any medication: ____yes _____ no

Explain: ____

Emergency Contact:

Name ____________________________ Phone # _____________________

Family History: (Please list all persons living in your home)

Name	Relationship	Age	Gender

Please list all children **not** living with you:

Name	Relationship	Age	Gender

Employer: ____

Your occupation: ____

Occupation of spouse or partner if living with you: _______________________

Self Assessment:

1. Do you feel depressed? ___Often ___Sometimes ___Rarely ___Never
2. Do you get angry easily? ___Often ___ Sometimes ___Rarely ___Never
3. Do you feel anxious? ___Often ____Sometimes __Rarely ___ Never
4. What do you do in your leisure time? (Interests, hobbies, groups, etc.):
   ____
5. Do you drink alcohol? ____Daily _____Weekly ______ Rarely ______Never
6. Do you consider alcohol to be a problem in your life? ___ yes ____ no
7. Does anyone else think that alcohol is a problem in your life? ___ yes ____ no
   If yes, who? ____
8. Do you take addictive drugs? ____Daily _____Weekly ____Rarely ____Never
   Do you consider them to be a problem in your life? ___ yes ____ no
   Does anyone else consider them to be a problem? ___ yes ____ no
   If yes, who? ____
9. Do you use marijuana? ____Daily _____Weekly ____Rarely ____Never
   Do you consider it to be a problem in your life? ___ yes ____ no
   Does anyone else consider it to be a problem? ___ yes ____ no

If yes, who? ____

10. Have you ever thought you might have an eating disorder? ___ yes ____ no

11. Were you physically punished while growing up?

___ yes ____ no   If yes, by whom? _______________________________

12. Were you sexually molested while growing up? ___ yes ____ no

If yes how often? _________________At what age? _________

If yes, check all that apply: ____Attempted rape _______Actual rape

______Touching genitals

Other: ____

By who? ____

13. Have you ever hit your parter: ____ no

_____1 time ___2 times ________3-6 times _______ over 6 times

14. Has your partner ever hit you? _____ no

_____1 time ___2 times ________3-6 times _______ over 6 times

When was the last hitting incident? ____________________________

15. Please share any medical or mental health concerns, or any other concerns you may have.

____

____

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Client's Signature ____

Date ____________________

All Information Will Be Kept Confidential As Permitted By Law