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Client Name _____ Marital
Status _____

Age ___ Date of Birth _____ Street address

Town and Zip
Code _____

Home Phone: _____ Cell
Phone _____

Name and Ages Of
Children _____

Emergency contact:

Phone _____
Relationship _____

Prescription medications

Serious illnesses,
Accidents, Operations, Allergies _____

What brings you here at this
time? _____

Previous Therapy Experiences: ___ No ___ Yes

Therapist _____ Amount of Time _____

Psychiatric Hospitalization ___ No ___ Yes

Hospital: _____ Amount of Time _____

Use of Alcohol ___ No ___ Yes

(if yes) Times per: Day _____ Week _____ Type _____

Amount _____

Use of Drugs ___ No ___ Yes

(If yes) Times per: Day _____ Week _____
Type _____ Amount _____

Eating Disorder: ___no ___yes
(if yes) Type _____ How Long _____

History of Sexual Abuse: ___no ___yes
___Sexual Intrusion ___Molestation ___Rape ___Sexual Harassment ___
Other _____

Physical Abuse: ___no ___yes
(if yes) Type _____ For how long _____

Gambling ___no ___yes
(if yes) Type _____ For how long _____

Suicidal Tendency: ___no ___yes
(if yes)

Explain _____

Significant Other Suicidal Tendency: ___no ___yes
(if yes)

Explain _____

Additional Information you would like me to know about:

Referred By: _____ **May I thank the person who referred you?**

Signature _____ **Date** _____