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Client Name: _____ *Marital Status:* _____

Age: _____ *Date of Birth:* _____ *Social Security Number:* _____

Address: _____

Home _____ *Cell Phone:* _____ *Work:* _____

Name and Ages of Children: _____

Name of person to contact in case of emergency: _____

Phone: _____ *Relationship:* _____

Serious Illnesses, Accidents, Operation and Allergies: _____

Previous Psychiatric Treatment: _____

What brings you here at this time? _____

Previous Therapy Experiences: _____ *no* _____ *yes*

Therapist: _____ *Amount of time:* _____

Psychiatric Hospitalization: _____ *no* _____ *yes*

Hospital: _____ *Amount of time:* _____

Family or Significant Other(s) 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 _____ *For how long* _____

History of Sexual Abuse: _____ *no* _____ *yes*
_____ *sexual intrusion* _____ *molestation* _____ *rape* _____ *sexual harassment* _____
_____ *other*

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: _____

Referred By _____

Signature of Client _____ *Date:* _____

Signature of Patient (if minor): _____ *Date:* _____