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### Client Information and History Form

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*Instructions: Please complete all sections. Write "same" if information is contained in, or the same as, previous sections.*

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Today's Date:

Client Name:

Date of Birth:

Social Security No.:

Mailing Address:

Physical Address:

Circle One: Married    Single    Divorced    Separated

OK to leave a message?

Which is preferred number?

Home Phone:

Y    N

Work Phone:

Y    N

Cell Phone:

Y    N

Your employer and position:

How Long?

Highest Education completed:

If married, Spouse's Name:

Spouse's Date of Birth:

Mailing Address if different:

Physical Address if different:

Spouse's employer and position:

How Long?

Spouse's Highest Education completed:

How did you hear about me?

To whom will bills be sent?

Address & telephone (if different than the client's):

Primary Care Physician:

Phone:

Contact in case of emergency (name and phone):

Relationship:

Responsible Party:

Relationship:

Social Security No.:

Date of Birth:

Religious preference:

**HOUSEHOLD & MISC INFORMATION:**

NAME                                      AGE                                      RELATIONSHIP                                      HOW CLOSE TO CLIENT

NAME	AGE	RELATIONSHIP	HOW CLOSE TO CLIENT

Is there any legal involvement?                      If yes, please explain:

Is an evaluation or participation in psychotherapy required of you by anyone (eg, court or employer)?

Y   N

**Medical Information**

Current Primary Physician:

Address:

Phone:

Date of last exam:

Any current medical problems:

Current medications and dosages:

List below any significant medical history (illness, operations, conditions):

**Mental Health History**

Are you currently in counseling or receiving mental health or substance abuse services from any other provider?                      Y   N

If so, please list who you are seeing and the dates of service:

Are you pleased with the services you have received either in the past?    Y   N

Why or why not?

Have you ever received counseling, mental health, or substance abuse services in the past?   Y   N

If so, please list where and why:

Approx Dates	Provider or Institution Name	Reason

Why are you seeking services now?

Have you ever taken medication for psychiatric reasons in the past? Y N

If yes, please list below:

Approx Dates	Name of Medication	Reason

Have you ever had psychological testing? If so, approximately when and where?

Has anyone in your family had, or been in counseling or treatment for a mental health or substance abuse condition? Y N If yes, please list below:

Relation	Condition and/or Treatment

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I have completed this form with information that is true and accurate to the best of my knowledge.

Date: \_\_\_\_\_ Responsible Party Signature \_\_\_\_\_

Printed name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_