

Today's Date:

### Client Information

Full name

Date of Birth

SS#

Address

Home phone

Work phone

Cell phone

email

In case of emergency,  
please notify:

Who to thank for referral:

### Background Information

Previous Therapy?

Name of Therapist:

Dates and duration of Therapy:

Reason for Termination:

What was helpful in your past therapy?

Current Medications:

Prescribing Physician Name and Contact Info:

Family Names and Ages (parents, siblings, spouses/partners, children, include half and step)		
Current Spouse or Partner?		
Please check any of the following which apply to you now or in the past:		
headaches	depression	drug use/problem
fatigue	PMS (women)	sexual problems
panic	anxiety/tension	sexual abuse
memory problems	drinking too much	physical abuse
poor concentration	blackouts	low self-esteem
suicidal feelings	insomnia	medical issues
suicide attempt	trauma	other stressors not listed
overnight hospitalization	drug use/problem	

### Payment Information

Responsible Party's Full name:

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Home phone

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Work phone

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Cell phone

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Address (if different from above)

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Responsible Party's Signature

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Date

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