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I. CLIENTS INFORMATION

Client: _____ Date of Birth: __ / __ / __

Address: _____

City: _____ State: _____ Zip: _____

Cellular Telephone: (____) _____ Home Telephone: (____) _____

Sex: ☐ Male ☐ Female S.S. #: _____-_____-_____

Legal Guardian: _____ Telephone #:_____

Employer/School: _____ Telephone #: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐Separated
☐ Widowed ☐ Live with partner

Insurance:

Name of Insured: _____

Insured's Date of Birth: ___ / ___ / ___

Insurance Name and Plan: _____

Insured S.S. #: _____ - ____ - _____ Insured's ID #_____

Insured Group #_____

Relationship to the Insured_____

Other Insurance Plan_____

Emergency Contact:

Name: _____

Relationship: _____

Phone: _____

II. MEDICAL HISTORY

1. Health Problems ☐No ☐ Yes If yes, briefly describe _____
_____

_____

2. Medications (dosage, dates of initial prescriptions, name of prescribing professional):
_____
_____

3. Allergies/adverse reactions to treatment:
_____
_____

4. History of Suicidal/ Homicidal Behavior: ☐No ☐Yes If yes, briefly describe
_____
_____

5. Substance Use History(Hx) ☐ No ☐ Yes Trauma Hx ☐No ☐Yes If yes, to any, briefly describe:_____

_____

Psychiatrist Name: _____Telephone: _____

Address:_____

City_____ State: ____ Zip:_____

Client Signature_____ Date _____

Therapist Signature_____ Date _____