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I. CLIENTS INFORMATION

Client: _____ Date of Birth: ___/___/___

Address: _____

City: _____ State: _____ Zip: _____

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

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

Legal Guardian: _____ Telephone #:_____

Employer/School: _____ Telephone #: _____

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

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 q Yes q 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 q Yes q If yes, briefly describe

_____

_____

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

_____

_____

Psychiatrist Name: _____Telephone: _____

Address:_____

City_____ State: ____ Zip:_____

Client Signature_____ Date _____

Therapist Signature_____ Date _____