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Client Information

Instructions: Please fill out this form as completely as possible and please print or write legibly. If you need more room to complete any section, continue writing on the back of that page. If certain questions do not apply to you, write NA. If you have questions or concerns about any items, please discuss them with your clinician. All information is CONFIDENTIAL.

Your Name (First, Middle Initial, Last)

_____

Address_____

City/ Region/ Post Code_____

Phone #s: Home _____

Work_____ **Cell:** _____ **Ok to text?** _____

Email :_____**Ok to Email Statements/Invoices?**_____

Do you want us to use discretion when calling you or leaving messages at any of the phone #s?

No____ **Yes**____ **(If Yes, please be specific)** _____

Age_____ **Birth Date**_____

Occupation_____

Employer_____

Single____ **Married**____ **(# years**_____**) Partnered**____ **(# years**_____**) Separated**____ **Divorced**____

Widowed____ **Other**____ **(specify)**_____

Names and ages of children_____

_____

Spouse's/Partner's Name_____

Age_____

Spouse's/Partner's Occupation_____

Significant medical problems you have or had_____

_____

Current Physician: _____ **Phone #** _____

Current medications you are taking_____

_____

If you have had any previous mental health and/or substance abuse treatment (outpatient and inpatient), list the type and approximate start and end dates for each:

_____

_____

_____

_____

_____

If you are currently working with any mental health professionals (including psychiatrists), list their names, profession, phone number and address and length of time you have been working with them:

_____

_____

_____

_____

SIGNATURE

Please sign in all the appropriate places:

ALL CLIENTS SIGN HERE

I certify that all the information I have provided above is accurate to the best of my knowledge. If any of the information changes I will provide updated information my clinician as soon as possible.

_____ _____

Client Signature **Date**