CLIENT INFORMATION

Today's Date: _____/_____/_____

Last Name: _____ First:_____ MI:____

Address: _____

City: _____Zip: _____

E-mail:_____

D.O.B:_____/_____/_____ Sex: ▫ Male ▫ Female

Cultural/Ethnic Designation(s):_____

Marital Status: ▫ N/A child ▫ Single ▫ Married ▫ Domestic Partner ▫ Divorced ▫ Widowed ▫ Separated ▫Other_____

Please provide your email and all available phone numbers and check the boxes ☑ that are acceptable for me to contact you and leave messages.

▫ **Email:**

▫ Cell Phone: ( ) _____-_____

▫ Home Phone: ( ) _____-_____

▫ Work Phone: ( ) _____-_____

Emergency Contact: Name & Phone Number:

_____(____) _____-_____

I will be personally responsible for all charges: _____

Please Initial

Referral Source: ▫ Self ▫ Family ▫ Co-worker ▫Other_____

Please promptly advise me of changes that affect the information on this form.

1. NAME OF SPOUSE/PARTNER _____ Length of relationship_____

2.. Spouse/Partner's date of birth _____ _____TEL_____

CLIENT INFORMATION (*cont'd*)

3. CHILDREN NAMES and Ages:

4. YOUR PRIMARY CARE PHYSICIAN _____TEL_____

ADDRESS_____

Number Street City State Zip

Date of most recent medical examination_____Results _____

_____

5. Do you have any medical risks? □ Yes □ No; If yes, please explain:

6. Are you **currently** taking any medication? □ Yes □ No; If yes, fill in below.

Name of Medication	Dosage	Frequency	Date Started	Who Prescribed?	Psychiatrist? or Medical Dr.?	Phone # of Prescriber

7. Do you feel that you are abusing any substance(s)? If so, please specify:

Type of Use*	Substance	Quantity	Frequency	Last Used	Ability to Abstain?	Any Prior CD Treatment?

*Types of use: (A) Abuse (D) Dependence (UM) Unstable remission

8. Does any significant substance abuse or dependence now exist in your living situation? This includes you, any partner, or anyone in your immediate family or household. □ Yes □ No

9. Is there any **Current** physical or sexual abuse, or child/elder neglect happening? □ Yes □ No

If yes, please talk with me about this immediately.

10. Are you currently in danger of hurting yourself or someone else? □ Yes □ No
If yes, please talk with me about this immediately.

CLIENT INFORMATION (*cont'd*)

11. Are you having trouble controlling impulses? □ Yes □ No
If yes, please check: □ moderate □ minimal □ inconsistent □ explosive

12. If there is any **significant history** of suicidal, homicidal, impulse control, medical or substance abuse behavior that may affect your current level of risk or impairment to functioning, Please explain:

13. Please describe symptoms and how they impair functioning (or place you at risk) in each area below:

Use This Severity Rating Scale:

--0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10—

Not a Problem ***Mild*** ***Moderate*** ***Severe*** ***Could Not Be Worse***

Area	Severity	Brief Description
Job		
Family/Relationships		
Other (describe)		

14. Please describe anything that you feel may get in the way of you reaching your goals:

15. Please describe anything that you feel might assist in your therapy: