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CONFIDENTIAL CLIENT INFORMATION SUMMARY

Today's Date: _____

Name _____ Date of Birth_____ Age _____

Address _____ City _____Zip Code _____

Employer/Occupation _____ _____

Messages ok? _____ Home Phone _____ Work/Other _____ Cell _____

Marital Status:
Never Married Live Together/Married Widowed Divorced/Separated(when/how long?) _____

Please list all family members or other people living in your home:

Name	Relationship	Date of Birth/Age	Gender	School or Occupation/Place of Employment

Medical Information

Current Medical Conditions _____

Medications or Treatments _____

Name of Physician _____ City _____ Phone _____

EMERGENCY CONTACTS

Name	Phone	Address

Have you been in therapy before: Yes No

Therapist's Name(s)	Approximate Time Frame	Reason for Therapy	Outcome

Have other family members been in therapy before? Yes No

Therapist's Name(s)	Approximate Time Frame	Reason for Therapy	Outcome

Please describe reason(s) for seeking therapy at this time:_____

Please circle any of the following that pertain to you:

Nervousness	Depression/Sadness	Anger/Agressive	School problems	Eating Difficulties
Shyness	Cry easily	Self Control	Drug/Alcohol Use	Head/Stomach Aches
Loneliness	Feeling inferior	Difficult to discipline	Legal Problems	Sleep difficulties
Fears	Fatigue/Energy	Difficulty with friends	Concentration/Memory	Nightmares
Separation	Loss of Interest	Suicidal thoughts	Difficulty relaxing	Troubling thoughts

Please list major changes you and your family have experienced during the past five years:
(death, loss, health changes, moves, school or job changes, stress or trauma)

Current Family Substance Use: please include: alcohol, caffeine, nicotine, non-prescription and prescription drugs.

Family Member	Substance(s)	Level of Use/Frequency

How were you referred to my office? _____

Thank you!