



Client information sheet

Your answers below are confidential. Please ask any questions you have in completing the form.

TODAY'S DATE _____ NAME _____

DATE OF BIRTH _____ SOCIAL SECURITY NUMBER _____

OCCUPATION _____

Address

Phone Numbers

May I leave a message?

STREET _____ DAY _____ YES NO

CITY/STATE/ZIP _____ EVE _____ YES NO

EMAIL _____ CELL _____ YES NO

MEDICAL INSURANCE COMPANY _____ PHONE _____

SUBSCRIBER ID # _____ INSURANCE CONTACT PERSON _____

PRIMARY CARE PHYSICIAN _____

PHONE _____ DATE OF LAST EXAM _____

DO YOU CURRENTLY SEE A PSYCHIATRIST? (circle one) YES NO

IF YES, NAME _____ PHONE _____

MAY I CONTACT YOUR PHYSICIAN(S) IF NECESSARY (circle one) YES NO

YOUR SIGNATURE (indicating your consent) _____

PLEASE LIST ANY HEALTH PROBLEMS FOR WHICH YOU CURRENTLY RECEIVE TREATMENT OR HAVE RECEIVED TREATMENT FOR IN THE PAST

LIST ANY MEDICATIONS (prescription and non prescription) THAT YOU ARE CURRENTLY TAKING:

TYPE	DOSE	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHO REFERRED YOU TO ME? _____



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PREVIOUS COUNSELING/THERAPY (circle one) YES NO

DATES _____ THERAPIST'S NAME _____

WHAT WAS HELPFUL OR NOT HELPFUL ABOUT ANY PREVIOUS COUNSELING/THERAPY?

Please indicate the current use and frequency of the following substances

	more than once a day	once a day	once every 2-3 days	weekly	monthly	yearly or less	never
alcohol							
non-prescription drugs							
prescription drugs							
nicotine							
caffeine							

HOURS OF SLEEP PER NIGHT _____ BEDTIME _____

WHAT KINDS OF FOODS/DRINKS DO YOU YOU HAVE MOST OFTEN? _____

ANY CONCERNS ABOUT EATING HABITS OR NUTRITION _____

HOW OFTEN DO YOU EXERCISE? _____ TIMES PER WEEK (circle one) DAY WEEK MONTH

WHAT TYPES OF EXERCISE DO YOU ENJOY? _____

HOW DO YOU SPEND YOUR TIME WHEN YOU ARE NOT WORKING? WHAT KINDS OF ACTIVITIES AND HOBBIES ARE YOU INVOLVED WITH? _____

WHO ELSE LIVES IN YOUR HOUSEHOLD? WHAT IS THEIR RELATIONSHIP TO YOU?



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EMERGENCY CONTACT _____ PHONE _____
RELATIONSHIP _____

PLEASE STATE THE REASON(S) WHY YOU ARE SEEKING COUNSELING AT THIS TIME

PLEASE LIST ANY COUNSELING GOALS YOU HAVE ALREADY IDENTIFIED

HOW MANY SESSIONS DO YOU THINK IT MIGHT TAKE TO ADDRESS YOUR CONCERNS? _____

With respect to the Health Insurance Portability and Accountability Act (HIPAA), the regulations regarding Protected Health Information (PHI) were provided to me by Confluence Family Therapy.

SIGNATURE

DATE



thank you.