Jennifer Shtrum M.A., LMFT #46038

Confidential Client Information

Date: Referred by: Therapist:

Client Name: Age: Date of Birth:

Home Address:

Home Phone: Work Phone: Other:

Insurance Company: Group #:

Phone #: Policy #:

Social Security Number:

Occupation:

Education Level:

Relationship status: Married☐ Partner ☐ Single ☐ Separated ☐
Divorced ☐

Partner/Spouse Name: Age:

Occupation:

Children's Names and Ages:

Were you raised by: Both parents☐ single parent☐ relative☐ other☐

Mother's Name: Age: Occupation:

Father's Name: Age: Occupation:

Sibling(s) (names and ages):

Why are you seeking counseling? ______________________________

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Do you or any of your family members or significant other have a history of:
(Check all that apply)

Alcoholism ☐ Drug Abuse (prescription and or street drugs) ☐

Nervous Breakdown ☐ Prolonged illness ☐ Eating Disorders ☐

Other ☐

If you checked any of the boxes please explain: ______________________________

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Are you taking any medications? ☐ Yes ☐ No
If yes, please list:

Medication name: Dosage: Reason for taking it:

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Do you have any significant physical problems? Yes☐ No ☐

If yes, please explain: ______________________________

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Have you had any previous psychiatric care or counseling? Yes ☐ No ☐

If yes, please explain: ____

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Have you ever been hospitalized for a mental disorder, drug or alcohol problem? Yes ☐ No ☐

If yes, please explain: ____

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Have you, any of your family members or significant other attempted suicide? Yes ☐ No ☐

If yes, please explain: ____

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Emergency Contact: ______________________ Phone: ______________________

Relationship to you: ____

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Client Signature Date