SDE

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CLIENT INFORMATION

Name: _____

Date of Birth _____ Age _____ Gender _____

Address: _____

_____

_____

Home Number:_____
Is it OK to leave a detailed message? Yes **O** No **O**
(If not a message with only contact and appointment information will be left on preferred method of communication)

Work Number:_____
Is it OK to leave a detailed message? Yes **O** No **O**

Cell Phone: _____
Is it OK to leave a detailed message? Yes **O** No **O**
(If not a message with only contact and appointment information will be left on preferred method of communication)

Clients Cell Phone: _____
Is it OK to leave a detailed message? Yes **O** No **O**

Email Address:_____
Is it OK to leave a detailed message? Yes **O** No **O**
(If not a message with only contact and appointment information will be left on preferred method of communication)

Preferred method of communication: Home **O** Work **O** Cell **O** Text **O** Email **O**

Marital Status: _____

Name of Partner or Significant other: _____

Emergency Contact Information:

Name: _____ Relationship:_____

Phone Number:_____

Referred by:_____

Do you have any children? Yes **O** No **O**
If yes, Please list:

NAME	AGE	GENDER
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Last grade completed in school? _____

Are you still in school? Yes **O** No **O** Grade? _____

Are you working? Yes **O** No **O** **Occupation? _____**

Primary Reason for Seeking Therapy:
_____
_____

Presenting Problems and/or Concerns:
_____
_____
_____
_____

Medical Concerns:
_____
_____
_____

Behavioral History/Concerns:
_____
_____
_____

Family history of mental health:
_____
_____

Family history of medical concerns:

_____

_____

Have you (client) had prior psychotherapy? Yes **O** No **O**

- If yes, with who: _____
- For how long: _____
- For what concerns: _____

Have you (client) ever been prescribed any psychiatric medications? Yes **O** No **O**
If yes, please list:

_____

_____

List any significant medical problems/history of client:

_____

_____

Please list current medications of client:

_____

_____

Allergies of client:

_____

_____

How often do you (client) drink alcohol and how much do you typically drink?

_____

_____

Do you (client) smoke cigarettes (if yes, how often)? Yes **O** No **O**

_____

Do you (client) have any concerns about your use of alcohol or drugs? Yes **O** No **O**
If yes, Please describe:

_____

_____