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Adult Client Information Form

Today's date: _____
Note: If you have been a client here before, please fill in only the information that has changed.

A. Identification
Your name: _____Date of birth: _____ Age: _____
Nicknames or aliases: _____ Social Security #: _____
Home street address: _____ Apt.:_____
City: _____ State: _____Zip: _____
Home/evening phone: _____ May we contact you at this number? ____YES ____NO
Cell phone number _____ May we contact you at this number? ____YES ____NO
E-mail address: _____
May we contact you at this e-mail address? ____YES ____NO

B. Referral: Who referred you to my office?
Name: _____ Phone: _____
Address: _____
_____
May I have your permission to thank this person for the referral? • Yes • No
How did this person explain how I might be of help to you? _____
_____
_____

C. Your medical care: From whom or where do you get your medical care?
Clinic/doctor's name: _____ Phone: _____
Address: _____
If you enter treatment with me for counseling, may I tell your medical doctor so that he/she can be fully informed and we can coordinate your treatment? • Yes • No
In the event of an emergency, may I contact your medical doctor and disclose necessary information so that he/she can be fully informed and we can coordinate your treatment? • Yes • No

D. Your current employer
Employer:_____ Address: _____
Work phone: _____Calls will be discreet, but please indicate any restrictions: _____

E. Marital History
Are you: Single_____Married_____Divorced_____Widowed_____Never Married_____
If you are married, how long have you been married?_____
If you are divorced, give the month and year that your divorce was granted_____
If you are remarried following divorce/death of spouse, give the date of the marriage_____
Are you currently separated from your spouse? _____ Yes _____ No
Are you contemplating separation or divorce? _____ Yes _____ No

Do you have children? _____ Yes _____ No
If so, please list their names and ages:_____
_____

F. Family Members (list those living in home with you):

Name	Age	Sex	Grade	Relationship to You
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

G. Medications:

Name of Medication?	Dosage/Mg?	Frequency?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

H. Any problems or concerns about your medications? _____ Yes _____ No
(If yes, have you talked to the prescribing physician?) _____

I. Emergency Contacts

List the name(s) of the person(s) who may be contacted by this office in the event of an emergency. Please be aware that the persons listed may receive information in an emergency situation that would otherwise be confidential by law. By listing the name(s) below, you give this office permission to contact the person(s) listed and provide necessary information about you in the event of an emergency.

_____
_____
_____

J. Chief Concern(s): Please describe the main difficulty that has brought you to see me: _____
_____
_____
_____

K. Have you ever received counseling services before? __No __Yes. If yes,

When?	With Whom?	For What?	With What results?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

L. Abuse History? _____I was not abused in any way. _____I was abused (sexual, physical, emotional, neglect) If you were abused:

Age of Abuse	Who did it?	Whom did you tell?	Consequences of telling?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

M. Health

List all illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other relevant medical conditions.

Condition	Age	Treated by whom?	Consequences?

N. Residences Outside your home**?** (Examples would be Foster Care, Residential Placement, etc) **____ No ___Yes** (If yes please complete below):

From	To	Location	Reason for moving	With whom	Any problems?

O. Education

Schools attended (Name and location)	Degree/Level Completed	Date Completed