

Client Information

Client Information

Name _____ Date of birth _____

Address _____ Social Security # _____

Phone Home _____ Cell _____ Work _____

E-mail _____ Single

Occupation _____ Married/Partnered

Address _____ Divorced

_____ Widowed

Spouse or Partner Information

Name _____

Work phone: _____ Cell phone: _____

What is your primary concern: _____

Previous or Current Psychological – Psychiatric – Medical Conditions

Please indicate all previous or current conditions or diagnoses you have received:

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Victim of Child Abuse - Domestic Violence |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> General Anxiety | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder | <input type="checkbox"/> Prior head trauma or loss of consciousness |
| <input type="checkbox"/> Other Psychological – Psychiatric – Medical – or Neurological Conditions (please specify):

_____ | |

Current Medications

Please list all medications currently taken or prescribed for you:

