



Understand. Heal. Grow.

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CLIENT CONTACT & INFORMATION SHEET

NAME: _____ BIRTHDATE: ____/____/____ AGE: _____

ADDRESS _____

STREET

TOWN

STATE

ZIP CODE

HOME PHONE (____) _____ - _____ CELL PHONE (____) _____ - _____

CIRCLE PRIMARY CONTACT NUMBER?

MAY A MESSAGE BE LEFT?

home phone / cell phone

yes/no

EMAIL ADDRESS _____

PLEASE NOTE EMAIL CORRESPONDENCE IS NOT CONSIDERED TO BE A CONFIDENTIAL MEDIUM OF COMMUNICATION.

EMERGENCY CONTACT INFORMATION

Name _____

Relationship _____

Phone Number (____) _____ - _____

PERSONAL HISTORY

What brought you to counseling?

HAVE YOU EVER PARTICIPATED IN THERAPY/MENTAL HEALTH SERVICES BEFORE?

yes/no

IF SO, WHERE HAVE YOU RECEIVED SERVICES?

DATE

LENGTH OF TREATMENT

HOSPITAL/AGENCY

TYPE OF CLINICAL SERVICE

PLEASE DESCRIBE THE FOLLOWING

Sleeping habits: _____ Hours/Night _____

Eating habits: _____

Appetite: low med high

Sexual Interest: _____

Energy level low med high

Describe your mood: _____

Activity Level: low med high

Current thoughts of suicide: yes/no

MEDICAL HISTORY

Who is your Doctor or Primary Care Practitioner? _____

Have you ever had medical problems? Please describe: _____

Do you have any known allergies or drug sensitivities?

Current medications and dosage: _____

SUBSTANCE ABUSE HISTORY:

How often do you drink and how much do you usually drink each time? _____

Do you use any drugs, not prescribed by your doctor? yes/no

If so, what, how often and how much? _____

Do you ever take more medication than your doctor has prescribed? yes/no

Have alcohol or drugs ever caused a problem for you? yes/no

FAMILY SYSTEM REVIEW:

Mother: Living/ Deceased

Father: Living/ Deceased

Siblings: (List in order of age, Including yourself)

NAME: (BROTHER/SISTER)	AGE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Significant Other/ Partner Name: _____

CHILDREN:

Name: _____ Age: _____ Do your children live with you? yes/no

Name: _____ Age: _____ If not, where do they live? _____

Name: _____ Age: _____

Has anyone in your family ever received care for mental health concerns or substance abuse? yes/no

Relationship: _____ Problem: _____

Relationship: _____ Problem: _____

Has anyone in your family ever committed suicide? yes/no

EDUCATION REVIEW:

Highest grade completed in school: _____

What problems, if any, did you have in school? _____

EMPLOYMENT REVIEW:

Current place of employment: _____ How long? _____

Type of work _____

LEGAL HISTORY REVIEW:

Have you ever had legal problems? Describe:

Other significant information:

Signature: _____ Date: _____