CLIENT INFORMATION FORM

CLIENT INFORMATION

NAME: ______________________ DATE OF BIRTH: ______________ DATE: ______________

ADDRESS: ______________________ CITY / STATE / ZIP: ______________________

PHONE: ______________ MOBILE: ______________ WORK: ______________

*EMAIL: ______________________ SOCIAL SECURITY NUMBER: ______________

MARITAL STATUS: ___________ ETHNICITY: ___________ PRIMARY LANGUAGE: ___________

CHILDREN (*names & ages*): ____

CURRENT JOB/OCCUPATION: ______________________ HIGHEST GRADE COMPLETED: ______________

NAME OF EMPLOYER: ____

SPOUSE / PARTNER INFORMATION

SPOUSE/PARTNER'S NAME: ______________________ SPOUSE/PARTNER'S PHONE: ______________

THEIR ADDRESS: ______________________ CITY / STATE / ZIP: ______________________

MEDICAL INFORMATION

LIST ANY CURRENT OR CHRONIC MEDICAL CONDITIONS: ______________________________

LIST ANY MEDICATIONS TAKING: ____

EMERGENCY CONTACT PERSON: ______________________ PHONE: ______________

WHAT ARE YOUR REASONS FOR SEEKING OUT SERVICES? ______________________________

____

HOW DID YOU HEAR ABOUT US? ____

LIST ANY COUNSELORS AND APPROXIMATE DATES OF PAST COUNSELING RECEIVED: ______________

____

INSURANCE INFORMATION

MEDICAL INSURANCE COMPANY: ______________________ PHONE: ______________

GROUP NUMBER: ______________________ ID NUMBER: ______________________

OFFICE USE ONLY

DIAGNOSIS: ______________________ ***INDIVIDUAL / GROUP / COUPLES***

LOCATION: __________ ***GROUP TYPE:*** __________ ***DAY/TIME:*** ______________ ***START DATE:*** ______________

FEE: ________ ***ORIENTATION LOCATION/DATES:*** ______________________________

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PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTONS THAT YOU ARE HAVING OR ARE CONCERNED ABOUT:

DEPRESSION	CRYING SPELLS	OVER-EATING	SELF-ESTEEM PROBLEMS
REDUCED ENERGY	SLEEPING TOO MUCH	RESTLESS SLEEP	PROBLEMS FALLING ASLEEP
AWAKING TOO EARLY	NIGHTMARES	HOPELESSNESS	THINKING ABOUT THE PAST
MEMORY PROBLEMS	NERVOUSNESS	FEELING INFERIOR	CONCENTRATION PROBLEMS
BEING SELF-CRITICAL	ANXIETY	STRESS	LACK OF ENJOYMENT OF USUAL THINGS
EATING TOO LITTLE	PANIC ATTACKS	IRRITABILITY	COMPULSIVE BEHAVIORS
HEADACHES	SUICIDAL THOUGHTS	FEELING NUMB	JOB/SCHOOL CONCERNS
SHYNESS	LONELINESS	RACING THOUGHTS	PROBLEMS MAKING DECISIONS
SEXUAL PROBLEMS	DIVORCE	MARITAL PROBLEMS	RELATIONSHIP PROBLEMS
FINANCES	GAMBLING	WORK PROBLEMS	WORRYING TOO MUCH
LEGAL CONCERNS	BEING A PARENT	DRUG ABUSE	STOMACH PROBLEMS
ANGER	AGGRESSION	SELF-CONTROL	PERFECTIONISM
MEDICAL PROBLEMS	ALCOHOL ABUSE	UNHAPPINESS	BODY IMAGE
			JEALOUSY

PLEASE LIST PAST DRUG AND ALCOHOL USE:

SUBSTANCE	***WHEN LAST USED***	***QUANTITY AND FREQUENCY OF USE IN THE PAST***
TOBACCO:	__________________	____
ALCOHOL:	___________________	____
MARIJUANA:	___________________	____
COCAINE / CRACK:	___________________	____
AMPHETAMINE / CRANK:	___________________	____
OTHER: _______________	___________________	____

*Note that by providing your email address you give Allies in Change consent to communicate with you via email.

THANK YOU