Client Information

Please fill out as much as you are comfortable sharing with me now.

Name _____

Age _____ Birthdate _____

Address _____

_____

Phone _____

Okay to text? ❑ Yes ❑ No

Is it safe to leave confidential voice message? ❑ Yes ❑ No

Medications (list all medications you are currently taking and dosage)

_____

_____

Medical conditions (list current medical conditions. For pain, include 0-10)

_____

_____

Happiness Level 0-10 _____

Alcohol / Marijuana / Recreational Drug Use (type, frequency, amount, duration, context)

_____

_____

_____

Suicidal Ideation: ❑ Sometimes ❑ Frequently ❑ Never ❑ Always on my mind

Homicidal Ideation: ❑ Sometimes ❑ Frequently ❑ Never ❑ Always on my mind

Reason for therapy (please list any symptoms you are experiencing):

_____

_____

Emergency Contact:

Name _____

Address _____

Phone _____

_____

Signature Date

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