

# 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 \_\_\_\_\_ Relationship \_\_\_\_\_

**Branch of military:**  Army  Navy  Marines  USCG  Airforce  Other

**Other Insurance?**  YES  NO Insurance Company and ID # \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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