



Client Contact Form

"Creating Life Balance Through Effective Solutions"

CLIENT INFORMATION:

Name: _____ Date of Birth: _____ Date: _____

Best # to reach you: Home/Work/Cell _____ May I leave a message? (Yes) (No)

Address: _____ City: _____

Zip: _____ May I mail to this address? (Yes) (No) Email: _____

How were you referred? Client/Ad/Website/Web Directory/Other: _____

Relationship Status: Circle all that apply - (Single) (Div) (Sep) (Married) # yrs _____ (Partner) # yrs _____

Others Living at Home: _____ Circle: _____

Name: _____ Age: _____ Relationship: _____ Troubled/Healthy/Distant/Close

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Employer/School: _____ Occupation/Grade Level: _____

How long have you worked there? _____ Education (List highest degree attained): _____

Primary Physician: _____ Phone: _____

List any significant health problems: _____

List any medications you are taking and dosage: _____

Have you sought therapy in the past? (Y) (N) If yes, when and with whom: _____

Give a brief description of your treatment: _____

Emergency Contact Information: Name: _____ Phone: _____

Relationship: _____ Address: _____

FINANCIALLY RESPONSIBLE PERSON: (If different from above)

Name: _____ Relationship to Client: _____

Phone: _____ Address: _____

ABOUT YOU:

What has led you to seek therapy? _____

What are your interests/hobbies? _____

What activities/groups are you currently active in? _____

Briefly describe your exercise routine: _____

Briefly describe your daily eating/nutritional habits: _____

Alcohol/drug of choice: _____ Frequency of use: _____

Briefly describe your sleep patterns (too much/little, initial, middle or terminal insomnia): _____

Are you currently practicing your spiritual beliefs (church, meditation, etc.)? _____