CONFIDENTIAL CLIENT INFORMATION

Client:_____ _____ ___/___/___
Last First Initial Age Birthdate

Home Address:_____ zip code: _____
Occupation:_____ Home Tel:(__)_____
Work Address:_____ Cell Tele:(__)_____

Spouse:_____ _____ _____
Age Occupation
Children:_____ _____ _____

Were you raised by: Both Parents____ Single Parent____ Rel.____ Other____

Father:_____ ____ _____
Name: Age Occupation:
Mother:_____ ____ _____
Name Age Occupation:
Other:_____

Brothers and Sisters (including yourself) in birth order: Name:_____
_____ ____ _____ ____ _____
Name: Age Name: Age Name:

Family History Of: Alcoholism____ Drug Addiction____ Suicide____
Mental Illness____ Chronic Illness____

Medications:_____ _____ _____
Significant Physical Problems:_____ _____
Previous psychiatric care and/or counseling? _____
_____

Current Drug/Alcohol use: Amt_____ Frequency_____
Amt_____ Frequency_____

Have you ever been hospitalized for a drugs/alcohol/psychiatric :_____

Family Doctor/Psychiatrist:_____ Tele:(__)_____

Emergency Contact:_____ Tele:(__)_____

Client's Signature_____ Date:____/____/____

Legal Guardian Signature:_____ Date:____/____/____