CLIENT INFORMATION

Date:_____

Name:_____ Home Phone:_____

Adress:_____City_____State_____Zip_____

Email:_____Cell Phone:_____

Age: _____ Birth Date: _____ Race: _____ Marital: M S W D

Occupation: _____Employer: _____

Employers Address: _____Work Phone: _____

Spouse: _____Occupation: _____Employer:_____

How many children? _____ Names and Ages of Children:_____

_____

Name of nearest relative: _____Phone: _____

How were you referred to our office? _____

Family Medical Doctor (first and last name): _____

When healthcare professionals work together it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Y N May we contact you by email if necessary? Y N

HISTORY OF PRESENT PROBLEM:

Purpose of this appointment: _____

_____

Have you ever had the same or a similar condition? Y N If yes, when and describe:

_____

_____

PAST HISTORY

Do you ever have: (Place a check mark by conditions that apply to you)

___ Anxiety ___ Eating Disorder ___ Depression ___ Post Traumatic Stress Disorder (PTSD)

___ Anger ___ Adoption Issues ___ Abandonment ___ Alchoholism ___ Drug Addiction

___ HIV Positive ___ Other. List: _____ _____

Have you had any major illness, hospitalizations or surgeries? Women, please include information about childbirth (include dates):

_____

Have you been treated for any health condition by a physician in the last year? Y N

If yes, describe:_____

(Continue on reverse side)