



Initial Client Information Summary

Date _____, 20____ Client's Social Security # _____

Client's Full Legal Name _____ DOB: _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ Message: Y / N (Work) _____ Message: Y / N

(Cell) _____ Message: Y / N Age _____ Gender ____F____M

Marital Status: Married Divorced Separated Widowed Single Occupation: _____

Name of Spouse/Guardian _____ Phone _____

Address _____ City _____ State _____ Zip _____

Person Responsible for Payment _____ Soc. Sec. # _____

Signature of Person Responsible for Payment _____ X _____
(Must be signed for services to begin)

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place _____ Phone _____ Hrs _____

Spouse: Place _____ Phone _____ Hrs _____

Insurance Information (This information is necessary although we do not accept insurance at this time.)

Primary Insurance _____ Secondary Insurance _____

Phone _____ Phone _____

Contract/ID# _____ Contract/ID# _____

Group/Acct# _____ Group/Acct# _____

Subscriber _____ Subscriber _____

Subscriber Date of Birth _____ Subscriber Date of Birth _____

Client's relationship to Subscriber _____ Client's relationship to Subscriber _____



Family
Counseling
Center

__Self __Spouse __Child __Other _____ __Self __Spouse __Child __Other _____

Emergency Information In case of emergency, contact:

Name (1) _____ Relationship _____ Phone _____ Work _____
 Address _____ City _____ State _____ Zip _____
 Name (2) _____ Relationship _____ Phone _____ Work _____
 Address _____ City _____ State _____ Zip _____

Medical Information

Physician _____ Phone _____
 Address _____ City _____ State _____ Zip _____
 Psychiatrist _____ Phone _____
 Address _____ City _____ State _____ Zip _____
 Specialist(s) _____ Phone _____

List any major medical problems, surgeries, hospitalizations and/or allergies.

(1)	(4)
(2)	(5)
(3)	(6)

List any medications currently being taken

Name of Medications	Dosage	Frequency	Length of Time on Meds

Mental Health Treatment History: Please list any previous psychological/psychiatric services & related information

Type of Service	Dates of Service	Provider	Reason for Service

Symptom List: Please circle all that apply

- | | | | | |
|--------------------|-----------------|--------------------|-----------------------|--------------|
| Worry | Poor appetite | Headaches | Nightmares | Stress |
| Impulsiveness | Depression | Excessive Appetite | Sexual Dysfunction | Shyness |
| Hallucinations | Guilt/Shame | Excitability | Weight Gain/Loss | Insomnia |
| Tense | Worthlessness | No need for sleep | Suicidal Thoughts | Sleepiness |
| Panic attacks | Stomach Trouble | Risky Behavior | Suicidal Attempt/Plan | Fatigue |
| Intrusive Thoughts | Helplessness | Racing Thoughts | Rage/Anger | Anxiety |
| No Appetite | Poor Memory | Harm to Others | Bedwetting | Intense Fear |



Other: _____

Problem Areas: Please circle all that apply.

Physical Health Parenting Marriage Family Financial
Emotional Health Relationships Legal Drugs Spiritual

Other: _____

Primary Reason(s) for Visit: _____

Do you have any pending legal issues and/or involvement with DCS? _____ Yes _____ No

If so, please explain: _____

Do you foresee needing our services for court? _____ Yes _____ No

THIS SECTION TO BE USED ONLY FOR MINOR CHILDREN					
Are biological parents:	Married	Separated	Divorce	Child resides	
with: _____					
Legal Guardian: _____		DCS Involvement?		_____ Yes	
_____ No					
Previous Abuse Issues?	Circle all that apply.		Emotional	Physical	Sexual
Name of School: _____		Grade: _____			
Parenting			Plan? _____		
Jurisdiction _____					

Referral Source

How did you hear of our clinic (or from whom)? _____

Date

Client Signature

Date

Client Signature