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CLIENT RECORD

Patient:_____ DOB:_____ Current age:_____

Address:_____ City:_____ Zip:_____

Cell Phone: (____)_____ Home Phone: (____)_____ Work Phone: ____)_____

Gender: Male____ Female____ Marital Status: Married____ Single____ Divorced____ Widowed____

Emergency Contact: _____ Telephone: (____) _____

Employer / School Job Title / Grade

_____

Relevant medical conditions (history, current condition, changes in condition)

_____

Medications (dosage, length of time, prescribing clinician)

_____

Allergies / Adverse reactions to treatment

_____

Reason for seeking therapy: _____

_____

Treatment goals: _____

_____

Previous psychological or psychiatric treatment:

_____

_____

Psychiatric hospitalizations (dates and locations)

_____

_____

Family history of psychological or psychiatric treatment: _____

_____

Alcohol use: Y / N (# _____drinks weekly) Date last drank_____

Illegal drug use: (past or present) Y / N Date last used: _____ Type:_____

Family history of alcohol or drug use:_____

Legal History (past or present) Y / N Date: _____ Please explain_____ _____

_____

_____

Family Structure (please list others who live in your home / relationship / ages)

_____

_____

_____

Please circle any applicable experiences (past or present)

Domestic Violence	Traumas	Sexual Abuse
Physical Abuse	Sleep Problems	Eating Disorders
Suicide Attempts	Grief/Loss	Learning Problems
Suicidal Ideation	Cutting/ Self Harm	Visual Hallucinations
Anger Outbursts	Spending Sprees	Lying
Poor Concentration	Phobias	Mood Changes
Fatigue	Worry/ Fear	Panic Attacks
Racing Thoughts	Tearfulness	Hopelessness

What are your strengths?

_____ _____

_____

Motivation for treatment:

_____

_____

Other significant information:

_____

_____

_____

_____

Patient's Signature_____ Date _____

Therapist's Signature_____ Date _____