CLIENT DATA FORM

DATE: _____

Client name: _____
FIRST M.I. LAST

Address: _____

City/State/Zip: _____

Phones: (_____)_____ (_____)_____
Home Work

(_____)_____ _____
Other (e.g. cell) Email

Date of Birth: _____

Gender: ❑ MALE ❑ FEMALE

Optional:

_____
Health Insurance ID Number

_____
Health Insurance Plan

Please specify where you may be reached: ❑ Home ❑ Work ❑ Other ❑ No Preference

Name of Spouse or Partner_____ Date of birth _____ Gender_____

	Name	Age	Sex	Where living?
Children	_____	_____	___	_____
	_____	_____	___	_____
	_____	_____	___	_____
Others living with you	_____	_____	___	_____
	_____	_____	___	_____

Source of Referral
- ☐ Promotional Materials
- ☐ Work-site Presentation/Health Fair
- ☐ Co-worker
- ☐ HR/ New Employee Orientation
- ☐ Other

Method of first requesting service
- ☐ Phone
- ☐ Online

Age _____

Marital Status
- ☐ Never Married
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Domestic Partners

Education
- ☐ Grade School
- ☐ High School
- ☐ Some College
- ☐ 4 Year Degree
- ☐ Post Graduate
- ☐ Trade School

How would you best identify your ethnic group? Please check one or more of the following:

☐ African American or Black ☐ American Indian or Alaska native ☐ Asian
☐ Hispanic/Latino ☐ Native Hawaiian or other Pacific Islander ☐ White
☐ Multiracial ☐ I am unsure (unknown ethnic/racial origin) ☐ I prefer not to state

Yes	No		Please explain any marked *Yes*.
❑	❑	Do you have any medical problems?	_____
❑	❑	Are you currently taking any medication?	_____
❑	❑	Have you visited a physician in the last year?	_____
❑	❑	Have you ever been in counseling before?	_____
❑	❑	Has a mood-altering drug ever been prescribed for you?	_____
❑	❑	Have you ever been admitted to a psychiatric unit?	_____
❑	❑	Have you ever thought about or attempted suicide?	_____
❑	❑	Have you ever been admitted to an alcohol or drug dependency program?	_____
❑	❑	Have you or anyone in your family ever had a problem with substance abuse?	_____

As a result of the problem(s) that brought you to therapy, how many times in the past month have you:

_____ Had conflicts with a spouse or family member?
_____ Been unable to sleep?
_____ Engaged in binge eating or purging?
_____ Felt like hurting yourself – in any way?
_____ Felt down or hopeless?
_____ Felt so bad you wished you were dead?
_____ Felt little interest or pleasure in doing things?

In the past month, how often did you drink alcohol or use recreational drugs?

❑ Not at all ❑ Once a week or less ❑ 2-3 times/week ❑ Once a day or more

Do you feel you drink or use drugs to excess? ❑ Yes ❑ No ❑ Unsure

On a scale from 1 to 10 please rate the extent your work performance has suffered <u>over the past 30 days</u>:

1 2 3 4 5 6 7 8 9 10
No performance concerns — Serious performance concerns

On a scale from 1 to 10 please rate the extent to which you have been concerned about your health and overall well-being <u>over the last 30 days</u>

1 2 3 4 5 6 7 8 9 10
Not at all concerned — Extremely concerned

Is there anything else you think your counselor should know? _____

May we contact you about the quality of our services? ❑ Yes ❑ No