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Date_____

Name	DOB	Age
Address	City	Zip

Home phone: _(_____)_____Work: _(_____)_____Cell:_(____)_____

Is it okay for me to call you at (circle if OK): Home Work Cell

Occupation_____How long:_____

How long on present job:_____Employed by:_____

Last school grade completed/degree:_____

Birthplace:_____How long have you lived in this area:_____

Do you have a spiritual practice? Y___ N___ Please Describe:_____

_____

Are you (or have you been) in a significant relationship: Y ___ N ___ If so, please state type of relationship and duration (length), as well as dates, if ended: _____

_____

_____

_____

Referred by Name:_____ Relationship:_____

Emergency Contact: _____

Types of Help Desired

___Individual therapy ___Couple's therapy ___Family therapy ___Group Therapy ____Other

___Spiritually based therapy ___Don't know

___Consultation about someone else -- Who?_____

___Other: _____

1. Reasons for seeking help at this time:

2. Since when and for how long have these things bothered you?

3. What other kinds of help have you tried so far?

4. Please list previous therapy experiences:.

Year	Therapist	Location	Length of treatment	Type of treatment	Benefits

5. Check all items below that apply to your present condition:

___Headaches
___Dizziness
___Stomach troubles
___Bowel trouble
___Feel tense
___Irritable
___Unusual thoughts
___Strange experiences
___Weight change
___Always tired
___Can't go to sleep
___Can't stay asleep
___Nightmares
___Sexual problems
___Financial problems

___Depressed
___Panicky feelings
___Tremors or tics
___Always worried
___Unable to relax
___Feel worthless
___Can't make decisions
___Thoughts of suicide
___Ready to explode
___Job difficulties
___Can't get interested
___Use alcohol
___Use drugs
___Unable to have a good time

___Trouble concentrating
___Can't make friends
___Can't keep friends
___Feel apart from people
___Fear things I shouldn't
___Conflict within family
___Feel anxious
___Dealing with a death or serious illness
___Fear I will lose self-control
___Gender Issues
___Emotional/Physical/Sexual Abuse
___Feel hopeless
___Feel ungrounded
___Other (Please List)

6. What prescription or over-the-counter medication(s) have you used during this last year?

   Check those you are currently using.

Medication	Amount	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Serious medical problems, surgery, or accidents that have happened to you and approximately when these occurred? Are you currently having any medical problems?

8. Current legal involvement in (lawsuits, child custody issues, driving under the influence, etc.)?

9. Any history of substance abuse or chemical dependency? Treatment to date?

11. Anything else you would like me to know?

Client Family Data Sheet

Name(s)	City & State of Residency	Age	If Deceased, Age & Year of Death	Occupation	Quality of relationship
Significant Other					
Children					
Others Living in Household Now					
Father					
Mother					
Step Parents					
Sisters and Brothers (Order of Birth)					

Which relatives have (or had) emotional difficulties or mental illness-- including alcoholism, abuse issues, etc.?

Relative	Difficulty - Please Describe