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## Client Information Sheet

Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name (if different from legal name): \_\_\_\_\_

Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Education: \_\_\_\_\_

Relationship status: \_\_\_\_\_

Contact Information:

Phone number: Home: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_ Preferred contact method: \_\_\_\_\_

Emergency Contact- Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

## Medical and Health History

Please list all current or past health problems, major operations, or prescribed medications:

Current	Past

Please indicate which of these substances you currently use:

Substance	Amount, if used	How often?
Cigarettes		
Alcohol		
Caffeine		
Pills not prescribed for me		
Marijuana		
Cocaine or crack		
Ecstasy		
Hallucinogens		
Heroin		
Other (please list):		

Have you had psychotherapy in the past? \_\_\_\_\_ If so, when? : \_\_\_\_\_

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Signature

Date