

CLIENT INFORMATION

CONTACT INFORMATION

Date _____

Name _____ Age _____

Address _____

City _____ State _____ Zip _____

Home Ph _____ Msg ok? _____ Which number
is the best place
to reach you?

Work Ph _____ Msg ok? _____

Cell Ph _____ Msg ok? _____

Emergency Contact _____ Ph _____

Psychiatrist or MD _____ Ph _____

Relationship Status _____ Children? _____ Ages _____

Birthdate _____ Referred by _____

Email Address _____

BACKGROUND INFORMATION

Reason(s) for seeking therapy at this time (Circle all that apply):

Anxiety	Relationship Issues	Life Transition	Grief and/or Loss	Substance Abuse
Depression	Family Problems	Spiritual Issues	Loneliness	Past Sexual Abuse
Panic Attacks	School Issues	Chronic Illness	Low Self Esteem	Food/Eating Issues
Nightmares	Job Issues	Stress	Fear/Phobia	Suicidal Thoughts

Other (describe) _____

Goals for Therapy _____

Jeff Pincus, MSW, LCSW

CLIENT INFORMATION (continued)

Briefly Describe major losses or trauma _____

Previous Therapy? _____ When, How long, Outcome? _____

Have you ever attempted suicide? _____ If so, when, how, and what happened? _____

Have you ever been hospitalized for mental health issues? _____ If so, when? _____

Please describe _____

Drug/Alcohol use (past and present): _____

Medical Problems and Prescribed Medications _____

Do you have any spiritual or religious affiliation? _____

Current Household Members _____

Occupation: _____ Education _____