

Client History

Name _____ DOB _____ Today's Date _____

List symptoms you are experiencing, when they first started and how long they have lasted:

Please provide your Mental Health History, previous treatment, with whom and for how long?

Family Members with Mental Health Concerns: _____

Education, highest level achieved: _____

Current Job Status: _____ How long? _____

Medical history, current health: _____

Medications, Dose: _____

Herbals, Dose: _____

Allergies: _____

Alcohol Use (amount, frequency): _____

Cigarettes, cigar, other tobacco use (amount, frequency): _____

Recreational Drug Use (What, Amount, Frequency, Age of initial use): _____

Have you missed work due to drug use or drinking? ____ Have others expressed concern about your drug use or drinking? ____

Please List your Hobbies, Interests and Recreational activities:

Spiritual Preferences: _____

What do you hope to accomplish from your therapy?

Personal Physician: _____

Address: _____ City: _____ State: ____ Zip: _____

Patient's Signature: _____ Date: _____

Therapist's Signature: _____ Date: _____