



Client Information

Instructions: Please complete all of the following questions. This information will be helpful in serving your needs. This information is confidential (see confidentiality on disclosure statement)

Today's Date: _____

Name: _____

Address: _____

Phone (home) _____ (work) _____

Employer _____

Social Security Number _____ Date of birth _____

Insurance Carrier _____

Insurance ID Number _____ Subscriber _____ Date of birth _____

Family-Residence

Please give name of current spouse/significant other and length of relationship:

_____ Previous Marriages? _____

Currently living with: alone spouse significant other housemates children siblings
parents

Family Member (name) Age Rate the relationship 1-10 (1-poor, 10 very good)

Mother/wife _____

Father/husband _____

Child/siblings 1 _____

Child/siblings2 _____

Child/siblings3 _____

Child/siblings4 _____



Important Others _____

What is your birth order? Only Oldest Middle Youngest

Were you raised with both parents? Yes No If no please explain: _____

Any other family information that is significant? _____

MEDICAL-HEALTH INFORMATION

Primary Physician: _____ When was your last visit _____

Health concerns now or in the last 12 months _____

List all medications you are taking or have taken in the past month _____

Any other important medical-health information _____

MENTAL HEALTH-EMOTIONAL-BEHAVIORAL

Do you have concerns regarding your behavior or someone else's in any of the following areas: If it is someone else please indicate who/relationship:

Alcohol	y/n	Depression	y/n
Drugs	y/n	Anxiety/Nervousness	y/n
Eating Disorder	y/n	Sexual Relationship	y/n
Gambling	y/n	Communicating	y/n
Sexual Acting Out	y/n	Anger	y/n
Physical Abuse	y/n	Difficulty Setting Limits	y/n
Verbal Abuse	y/n	Parenting	y/n

Do you consume alcohol yes no How much per day? _____

Has anyone ever complained about your drinking y/n Who _____



Eastside Addiction Professionals
Counseling For The Whole Family

Have you or anyone in your family been treated for alcohol, drug, or other mental health issues?

If yes: Who _____ Relationship _____

For what _____ Where and when _____

Have you or anyone in your family ever attempted suicide yes no If yes who? _____

Have you had suicidal thoughts recently yes no Please explain _____

Do you smoke? yes no _____ # per day _____ per week _____

Do you get regular exercise yes no _____ If yes please describe _____

How satisfied are you with your life in general 1 not at all, 10 very much _____

Please list your strengths _____

THERAPY

Who referred you for therapy? _____

Why are you coming for therapy? _____

What are your goals for therapy? _____

How would you know you were achieving those goals? _____

Are you involved in any legal/disciplinary action right now yes no _____ If yes, is that why

you came to therapy? yes no If yes please explain _____

Please rate your level of willingness to work on this/these issues 1 not at all, 10 very much _____

Please comment on how you rated yourself _____

Anything else you would like me to know _____
