

Date: _____

Client Information page 1

Note: All personal information is held securely in accordance with the appropriate legislation, is confidential and treated appropriately.

Client Information

Full Name _____

Name you like to be called _____

Address _____

Telephone Numbers/Contact Details

OK to leave message?

Home _____

____ Yes ____ No

Work _____

____ Yes ____ No

Cellphone _____

____ Yes ____ No

Email/s _____

Preferred Contact Mode/s _____

Emergency contact (name and phone number)

Personal Information

Date of Birth _____

Marital Status _____

Significant Other's Name _____

Names and Ages of Children, if any _____

Occupation _____

Highest level of education completed _____

Name: _____ Date: _____

Client Information page 2

Previous counseling/treatment/hospitalization? Y/N If yes, please provide additional information:

Current medications and dosage:

Any chronic health issues? Y/N

If yes, please describe:

Please list other treating providers (physician, nutritionist, etc), if any:

Name _____ Phone _____

Name _____ Phone _____

History of, or current, self-harm behavior and/or suicidal thoughts/attempts: Y/N

If yes, please describe: _____

Please list current and past alcohol/tobacco/drug use:

Substance: Average amount and frequency: Last date of use:

_____	_____	_____
_____	_____	_____
_____	_____	_____