CLIENT INFORMATION

CLIENT NAME			
AGE	DATE OF BIRTH	RELATIONSHIP STATUS	SPOUSE'S NAME

ADDRESS	CITY	STATE	ZIP

HOME PHONE	OKAY TO CONTACT? ☐ YES ☐ NO	OKAY TO LEAVE MESSAGE? ☐ YES ☐ NO
WORK PHONE	OKAY TO CONTACT? ☐ YES ☐ NO	OKAY TO LEAVE MESSAGE? ☐ YES ☐ NO
CELLULAR PHONE	OKAY TO CONTACT? ☐ YES ☐ NO	OKAY TO LEAVE MESSAGE? ☐ YES ☐ NO
EMAIL ADDRESS		OKAY TO CONTACT? ☐ YES ☐ NO
OCCUPATION		

EMERGENCY CONTACT	RELATIONSHIP TO CLIENT
EMERGENCY CONTACT PHONE NUMBER	OTHER EMERGENCY CONTACT PHONE NUMBER

EDUCATIONAL HISTORY

HIGHEST GRADE/DEGREE COMPLETED: CURRENT SCHOOL:

DID YOU EXPERIENCE DIFFICULTY IN SCHOOL WITH ANY OF THE FOLLOWING:

☐ READING	☐ SPELLING	☐ MATH	☐ SOCIAL/PEERS
☐ BEHAVIOR	☐ ATTENDANCE	☐ AUTHORITY FIGURES	

HOW MANY SCHOOLS, INCLUDING GRADES K-12 DID YOU ATTEND?

OVERALL, HOW WOULD YOU DESCRIBE YOUR EXPERIENCES IN SCHOOL?

SOCIAL HISTORY

RELIGIOUS AFFILIATION:	☐ ACTIVE ☐ NOT ACTIVE
12-STEP SUPPORT GROUPS ATTENDED	
COMMUNITY/SOCIAL/POLITICAL ACTIVITIES:	

Referred By: ______________________________

______________________________ ______________________________

Signature of Client **Date** **Lauren Leising, MA, LMFT** **Date**

FOR OFFICE USE ONLY:

MEDICAL INFORMATION

CLIENT:	
PRIMARY CARE PHYSICIAN:	PHONE:
OB-GYN:	PHONE:

CURRENT MEDICAL PROBLEMS: INCLUDE MEDS FOR DEPRESSION, MOOD DISORDERS, ADHD, ETC.

CONDITION	AGE AT ONSET	HOW TREATED (INCLUDE MEDICATIONS AND DOSAGE)

PAST ILLNESSES, OPERATIONS OR ACCIDENTS

CONDITION	AGE	HOW TREATED

HAVE YOU HAD A HYSTERECTOMY? ☐ YES ☐ NO ☐ N/A	HAVE YOU HAD AN ABORTION? ☐ YES ☐ NO ☐ N/A	HAVE YOU GONE THROUGH MENOPAUSE? ☐ YES ☐ NO ☐ N/A
DO YOU USE BIRTH CONTROL? ☐ YES ☐ NO ☐ N/A	IF YOU USE BIRTH CONTROL, WHAT FORM DO YOU USE?	
PLEASE LIST ALL ALLERGIES, INCLUDING ALLERGIES TO MEDICATIONS:		
DO YOU RECEIVE TREATMENT FOR ALLERGIES? ☐ YES ☐ NO	IF YES, DESCRIBE:	
DO YOU EXERCISE? ☐ YES ☐ NO	IF YES, TYPE OF EXERCISE:	I EXERCISE APPROXIMATELY ______ (FREQUENCY) PER ______.
DO YOU TAKE ANY HERBAL/NATURAL SUPPLEMENTS? ☐ YES ☐ NO	IF YES, WHICH ONES?	
DO YOU HAVE ANY CONCERNS ABOUT YOUR WEIGHT OR BODY IMAGE? ☐ YES ☐ NO	IF YES, PLEASE EXPLAIN:	

WHICH OF THE FOLLOWING SUBSTANCES DO YOU USE?

SUBSTANCE:	TYPE	AMOUNT	FREQUENCY
Alcohol			
Caffeine			
Nicotine			
“Recreational” Drugs			
Pain Relievers			

Have you used any of the above-listed substances in the past? ☐ YES ☐ NO	If yes, briefly describe which ones and your reasons for stopping.
Are you concerned about how a family member may be using the above-listed substances? ☐ YES ☐ NO	If yes, briefly describe which ones and your concerns about it.

MEDICAL INFORMATION (Continued)

CLIENT:	
HAVE YOU EVER BEEN SUICIDAL? ☐ YES ☐ NO	IF YES, PLEASE DESCRIBE:
ARE YOU CURRENTLY SUICIDAL? ☐ YES ☐ NO	IF YES, PLEASE DESCRIBE:
HAVE YOU EVER BEEN HOSPITALIZED FOR MENTAL HEALTH CONCERNS? ☐ YES ☐ NO	IF YES, PLEASE EXPLAIN:
LIST ANY PAST OR PRESENT COUNSELING SERVICES (NAME OF PROVIDERS AND APPROXIMATE DATES)	
REASON FOR SEEKING COUNSELING AT THAT TIME, AND WAS IT HELPFUL?	
WHEN DID THIS PROBLEM BEGIN?	
WHAT MAY HAVE CAUSED IT TO START?	
HAS IT GOTTEN BETTER OR WORSE SINCE IT BEGAN? ☐ BETTER ☐ WORSE	DESCRIBE:
WHAT IS THE PROBLEM FOR WHICH YOU ARE SEEKING ASSISTANCE TODAY?	
WHAT CAUSED YOU TO SEEK PROFESSIONAL HELP NOW?	
WHAT HAVE YOU TRIED TO RESOLVE IT, AND WHAT HAS BEEN THE RESULT OF YOUR EFFORTS?	
WHAT/WHO DO YOU BELIEVE WILL HELP YOU THE MOST IN RESOLVING THIS CONCERN?	
WHAT/WHO DO YOU BELIEVE MAY HINDER YOU THE MOST IN RESOLVING THIS CONCERN?	
HAS THIS PROBLEM OCCURRED BEFORE? ☐ YES ☐ NO	IF YES, WHAT WAS DONE ABOUT IT THEN?
HOW WILL YOU KNOW WHEN THIS PROBLEM HAS BEEN, OR IS BEING RESOLVED?	

FAMILY HISTORY

PLEASE LIST OTHERS LIVING IN THE HOME OF THE CLIENT:		
NAME:	AGE:	RELATIONSHIP:
NAME:	AGE:	RELATIONSHIP:
NAME:	AGE:	RELATIONSHIP:
NAME:	AGE:	RELATIONSHIP:
DO YOU HAVE ANY CHILDREN LIVING WITH SOMEONE ELSE? ☐ YES ☐ NO IF YES, LIST CHILDREN'S NAMES AND AGES:		
WITH WHOM ARE THEY LIVING?	WHERE?	
HOW OFTEN DO YOU SEE YOUR CHILDREN, AND WHAT TYPE OF CONTACT DO YOU HAVE WITH THEM?		

FAMILY HISTORY (Continued)

WHERE WERE YOU BORN?	WHERE WERE YOU RAISED?
WERE YOU RAISED BY YOUR BIOLOGICAL PARENTS? ☐ YES ☐ NO	IF NO, PLEASE EXPLAIN:
DESCRIBE YOUR RELATIONSHIP WITH YOUR MOTHER AND FATHER:	
DESCRIBE YOUR RELATIONSHIPS WITH YOUR BROTHERS AND SISTERS:	
DESCRIBE ANY FAMILY PROBLEMS WHICH OCCURRED WHILE GROWING UP RELATING TO ALCOHOL/DRUG ABUSE, SEXUAL/PHYSICAL/EMOTIONAL ABUSE, OR MENTAL ILLNESS:	

CURRENT MARITAL STATUS	HOW MANY TIMES HAVE YOU BEEN MARRIED?	IF MARRIED OR LIVING WITH SOMEONE, HOW MANY YEARS?
DESCRIBE ANY CONCERNS IN YOUR MARRIAGE OR RELATIONSHIP WITH YOUR PARTNER:		

EMPLOYMENT HISTORY

CLIENT:	PLACE OF EMPLOYMENT:
LIST THE JOBS YOU HAVE HAD AND HOW LONG YOU HELD EACH DURING THE PAST FIVE YEARS, BEGINNING WITH YOUR MOST RECENT OR CURRENT JOB: 1. 2. 3.	
WHAT HAS BEEN MOST SATISFYING ABOUT YOUR EMPLOYMENT?	
WHAT HAS BEEN LEAST SATISFYING ABOUT YOUR EMPLOYMENT?	

LEGAL HISTORY

PLEASE INDICATE ANY INSTANCES OF LEGAL DIFFICULTIES, SUCH AS INDICTMENTS, ARRESTS, DWI'S, ETC. THAT YOU HAVE EXPERIENCED:
ARE YOU CURRENTLY INVOLVED IN ANY SORT OF LEGAL ACTION? ☐ YES ☐ NO.
IF YES, PLEASE EXPLAIN:
ARE YOU CURRENTLY, OR DO YOU ANTICIPATE BEING INVOLVED IN A CUSTODY DISPUTE? ☐ YES ☐ NO

Signature of Client/Representative   Date   Lauren Leising, MA, LMFT   Date