

2211 Corinth Avenue, Suite 307, Los Angeles, California 90064

Confidential Client Information

Date: Referred by: Therapist:

Client Name Age: Date of Birth:

Home Address:

Home Phone: Work Phone: Other:

Insurance Company: Group#
Phone# Policy#

Social Security Number:

Occupation: Education Level:

Relationship Status: Married Partner Single
 Separated
Divorced

Partner/Spouse Name: Age: Occupation:

Children's Names and Ages:

Were you raised by: both parents single parent
 relative
 other

Mother's Name: Age: Occupation:

Father's Name: Age: Occupation:

Brother's and Sister's (names and ages):

Why are you seeking counseling?

Do you or any of your family members or significant other have a history of:
(Check all that apply)

Alcoholism Drug Abuse (prescription and or street drugs)

Nervous Breakdown: Prolonged illness: Eating Disorders:

Other: If you checked any of the boxes please explain:

Are you taking any medications? Yes No If yes,
please list:

Medication name	Dosage	Reason for taking it
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any significant physical problems? Yes No
If yes, please explain:

