

### Client Information

Name	_____	Date of Birth	_____
Address	_____	Age	_____
Email	_____	Home Phone	_____
Occupation	_____	Work Phone	_____
Employer	_____	Cell Phone	_____
Physician	_____	Other Phone	_____
Emergency Contact	_____		
Marital Status	_____		
Spouse/Partner Name	_____		
Number in Home	_____		
Children	Names _____	Ages	_____
	_____		_____
	_____		_____
	_____		_____

Are you currently taking any medication? \_\_\_\_\_  
If so, what type? \_\_\_\_\_

Have you had any difficulties in the last 6 months with the following?  
If so, please explain:

Sleeping	_____	_____
Eating	_____	_____
Memory	_____	_____
Concentration	_____	_____
Anger	_____	_____
Aggressive Behavior	_____	_____
Anxiety	_____	_____
Panic	_____	_____
Social Relationships	_____	_____
School Functioning	_____	_____
Work Functioning	_____	_____
Obsessive Behavior	_____	_____
Guilt	_____	_____
Crying	_____	_____
Apathy	_____	_____
Avoidance	_____	_____
Sexual Dysfunction	_____	_____
Physical Complaints	_____	_____

