SUMMIT CENTER

Helping Every Child Reach New Heights

CLIENT INFORMATION FORM

Date: _____

Client Name: _____

Age: _____ Birth Date: _____ Gender: Male or Female

Marital Status: _____ If Married, How long? _____

Children? Yes or No If yes, what are their names and ages: _____

_____

Name of Spouse/Partner: _____ If divorced, how long? _____

Address: _____ City: _____ Zip Code:_____

Home phone #: _____ Work phone #: _____

Cell phone #: _____ e-mail: _____

Occupation: _____ Employer: _____

Referred by: _____

Billing Information

Person responsible for payment: _____

Home address (if different from above): _____

City: _____ Zip Code: _____

Medical Information/History

Please list any medical issues and when diagnosed: _____

_____

_____

Do you smoke?_____ If yes, how much: _____

Do you drink? _____ If yes, how much: _____

Current medications/dosages/Date prescribed: _____

_____

Name of Physician: _____Phone number: _____

Mental Health History

Psychotherapy: Current _____ Past _____

Dates _____

Name of therapist(s): _____

Current Concerns

Anxiety ☐ Depression ☐ ADD/ADHD ☐ Learning Issues ☐ Career Issues ☐

Workplace Issues ☐ Relationship/Marital Issues ☐ Family Issues ☐ Parenting Issues ☐

Other: _____

_____

Goals of Treatment/Consultation

_____

_____

_____

_____

_____

_____

_____

_____