HEALING REINS
growth with unbridled potential

CLIENT INFORMATION

Date: _____

Name: (first) _____ (middle) _____ (last) _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Email: _____ Preferred method of contact: _____

May I leave a message for you? yes ____ no ____ or only at the following: _____

Date of birth: _____ Age: _____ Sex: _____ Soc. Sec. #: _____-_____-_____

In emergency, please call:

Name: _____ Relationship: _____

Address: _____ Telephone: _____

How did you find us?

CLINICAL INFORMATION

1. THERAPY EXPERIENCE
   Previous counseling/therapy: Please include when, how long and reason for ending.

   _____

   _____

2. MEDICAL HISTORY Approximate date of last general exam: _____

   Significant past physical problems: _____

   _____

   Head trauma? Yes ___ No ___ Circumstances and date _____

   _____

Psychiatric hospitalizations? Yes ___ No ___ Approx dates: _____

Other hospitalizations? Yes ___ No ___ Approx dates: _____

Major surgeries (Type and date) _____

3. DRUG AND ALCOHOL USE

Drugs (type/duration of use, prescribed or not):

Past _____

Currently _____

Alcohol (amount and duration of use):

Past _____

Currently _____

Complications from use, if any (physical, occupational, social, etc.)

_____

4. FAMILY ILLNESSES

(Please note significant physical problems, nervous breakdowns, depression, alcoholism, etc.)

_____

5. PERSONAL HISTORY

Highest educational level achieved: _____

Current occupation: _____

Marital status: Single ___ Married ___ If so, how many years: ____

Divorced ____ If so, when? _____ How long were you married? _____

Separated ____ If so, how long? _____ How long were you married? _____

Children: (age[s], names[s]): _____

Reason for seeking therapy at this time:

_____

_____