



CLIENT INFORMATION	COMPLETE FRONT AND BACK
For office use only	Diagnosis Code:

DATE: _____

NAME _____ DOB _____

ADDRESS

MARITAL STATUS: S M D W

Please provide the phone numbers at which you would like to be contacted by your SCCA mental health professional and/or office staff: Home _____
Office: _____ Cell _____

May we leave a message on your voice mail: Yes _____ No _____
Best time to reach you? _____

DRIVER'S LICENSE NUMBER AND STATE	
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LENGTH OF CURRENT EMPLOYMENT _____

EMPLOYER _____

WORK ADDRESS _____

EDUCATION

PARTNER OR PARENT'S NAME _____

ADDRESS _____ DOB _____

HOME PHONE _____ WORK PHONE _____

EMPLOYED BY _____

LENGTH OF EMPLOYMENT _____

EDUCATION _____

CHILDREN	SCHOOL	AGE
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RELIGIOUS AFFILIATION _____

DOCTOR'S NAME AND PHONE NO. _____

NEAREST RELATIVE OR CLOSE FRIEND _____

PHONE _____

REFERRED BY _____



MAY I HAVE PERMISSION TO THANK YOUR REFERRAL SOURCE: YES _____ NO _____

DO YOU NEED A STATEMENT TO FILE WITH YOUR INSURANCE COMPANY?

YES _____ NO _____

REASONS FOR SEEKING COUNSELING AT THIS TIME

DO YOU, YOUR SPOUSE OR OTHER SIGNIFICANT PEOPLE IN YOUR LIFE HAVE ANY HEALTH PROBLEMS? IF SO, PLEASE EXPLAIN.

DO YOU, ANY FAMILY MEMBER(S) OR OTHER SIGNIFICANT PEOPLE IN YOUR LIFE HAVE PROBLEMS, PAST OR PRESENT, WITH DRUGS OR ALCOHOL? IF SO, PLEASE EXPLAIN.

CURRENT MEDICATIONS:

HAVE YOU HAD PRIOR PSYCHOTHERAPY? YES OR NO. IF YES, WHEN AND WITH WHOM?

ARE YOU PRESENTLY HAVING SUICIDAL THOUGHTS? YES _____ NO _____

HAVE YOU EVER ATTEMPTED SUICIDE? YES _____ NO _____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE TO SHARE
