

Client's History

Contact Information

Name: _____ Sex: M / F (circle one)
Name of Guardian (if applicable): _____
Address: _____ Cell Phone: _____ Home Phone: _____
City, Zip code: _____ DOB: _____ Place of Birth: _____
Occupation: _____ Email: _____
How did you find out about Patrick Sassoon? _____
Marital Status: _____ Educational Level (highest level achieved): _____

Emergency Contacts

1st Emergency Contact Name and Phone: _____
Relationship to client: _____ Permission given by client to contact: Yes _____ No _____
Client / Guardian signature: _____ Date: _____
2nd Emergency Contact Name and Phone: _____
Relationship to client: _____ Permission given by client to contact: Yes _____ No _____
Client / Guardian signature: _____ Date: _____

History

Are you currently receiving psychological / psychiatric treatment? Please describe: _____

Provider's name and phone: _____

Permission given by client to contact: Yes _____ No _____ Client Signature and Date: _____

List all medications and dosage that you are currently taking, and the conditions they are for.

Please describe the nature of your main problem(s): _____

How long has the problem(s) been going on, and with what frequency? _____

How does the problem(s) affect your life? _____

What do you hope to gain from Counseling?

