

CLIENT BACKGROUND INFORMATION

Please provide some background information with the understanding that it will become a part of your record and it will help me gain a better understanding of you. Please answer every item, or write N/A if the item is not applicable.

Registration Information

Date: _____

Name: _____

SS#: _____ Driver's License: _____

Address: _____

Phones: Home: _____ Work: _____ Cell: _____

Next of kin or person who can be contacted in case of emergency:

Name	Relationship	Phone
------	--------------	-------

Family Background

Birthdate: _____ Birthplace: _____ Age: _____

Parents: Father (age): _____ Mother (age): _____

Siblings: Brothers (ages): _____ Sisters (ages): _____

Step-brothers (ages): _____ Step-sisters (ages): _____

Legal status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

If married, how long have you been married? _____

Name of Spouse or Partner: _____ Age: _____

Children: Sons (ages): _____ Daughters (ages): _____

Step-sons (ages): _____ Step-daughters (ages): _____

Who is currently living in your household? _____

Vocational Background

Occupation: _____ Employer: _____

How long have you worked for your present employer: _____

Current job title or description: _____

Previous employer: _____

How long did you work for your previous employer: _____

Previous job title or description: _____

Career goals: _____

Educational Background

Graduate: _____ Degree: _____ Year: _____

College: _____ Degree: _____ Year: _____

High School: _____ Diploma: _____ Year: _____

Military Background

Branch: _____ Enlistment: _____ Discharge: _____

Highest military rank: _____

Legal History

List the dates and details of any history of arrests, legal problems, or any legal problems pending:

DUIs: _____

Arrests: _____

Legal problems: _____

Legal problems pending: _____

Medical Background

Physician: _____ Date of last physical exam: _____

List any medical conditions that you have had and dates they were diagnosed: _____

List any surgical operations that you have had and dates they were performed: _____

List any psychiatric hospitalizations that you have had and dates you were hospitalized: _____

List any allergies or adverse reactions to medications: _____

List any medications (including over-the counter medicines) that you take: _____

List any substances (including tobacco and alcohol) that you use: _____

List any illegal drugs or substances that you use: _____

Approximately how many drinks of alcohol do you drink in a week? _____

Counseling Background

Have you ever been in counseling or therapy before? _____

If so, when, with whom, and for what reasons were you in counseling or therapy? _____

What is the reason that you are seeking counseling or therapy at this time? _____

What values do you consider most important in your everyday life? _____

Religious/ Spiritual Background

What was the religious background in which you were raised? _____

What is your current religious affiliation? _____

How important is spirituality to your everyday life? _____

Other Information

Please provide any other information that you think would be important _____

Client's Signature: _____ Date: _____

Interviewer's Signature: _____ Date: _____