

CLIENT INFORMATION

Last Name _____ First Name _____ Middle _____ Suffix _____

Type Referral
 Management Self

Contact

Address _____
 City _____ State _____ Zip Code _____

Family & Work

Gender _____ Date of Birth _____ Age _____ Relationship Status _____

Telephone

Home Phone _____ Cell Phone _____ Work Phone _____

Other Contact Information _____

Covered Employee Information

Employer Name _____ Division _____
 Name of Covered Employee _____

Emergency Contact

Contact Name _____ Relationship _____
 Home Phone _____ Cell Phone _____ Work Ph _____

Family

Family Member Name	Age	Relationship

Medical & Counseling History

Current Medical Problems (Please List all medical problems)

Current Problem

Briefly describe your reason for contacting us

Current Medications (Please list medication name & dosage)

How many months has this been a concern to you? _____

How serious would you rate this problem?
 Very Minor Minor Moderate Serious Very Serious

Have you used our service in the past? (If yes, provide details)

What counseling or treatment have you had in the past?

Are you having any problems at work?
 Absenteeism Safety Work Relationships
 Quality of Work Security Other _____
 Quantity or Work Tardiness _____

Details of other Work Problems

Counselor Signature _____

Credentials _____