Materniak Counseling and Family Therapy

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Client Information

Todays Date______________

Client Name____ DOB ________________

Address_______________________________________

____

Home Phone_______________________________ Cell Phone________________________________

Okay to leave a message? Yes No Email____________________________________

How did you hear about my practice? ____

Family/ Social History

Married? Yes No How Long?

If single, currently in relationship? ____

Prior marriages/divorces ____

____

Children (names/ages) ____

____

Parents/Guardians (name/ nature of relationship) ____

____

Siblings (names/ages) ____

____

Physical and mental health history in family ____

____

____

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Social supports (friendships/relatives/pets)____

____

Activities____

Education ____

Employment____

Religious/Spiritual Affiliation____

How important is religion/spirituality to you on a scale 1(low)-10(high)? _________

Mental Health History

Prior Treatment____

____

What was helpful/not helpful? ____

History of trauma, including abuse or neglect ____

____

Current or Past SI/HI? YES NO

If YES, please describe (time, intent, means, treatment, etc.)__________________________________

____

Medications ____

Substance Use (type/amount/frequency)____

____

Presenting Concerns

What brought you in today? ____

____

____

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Any additional information you feel I should know____

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