New Client Information

Name_____
First Last M.I.

Date of Birth_____ Email_____

Address_____ Phone_____

_____ Alternate Phone_____

Wedding Date _____

How did you find out about this office? _____

Children/members of household:
Name Date of Birth Relationship

1)_____

2)_____

3)_____

Emergency Contact_____ Phone_____

Physician_____ Phone_____

Current or Chronic Health problems_____

_____

_____

Do you think alcohol or drug use has ever been a problem for you? _____

_____

Regular Medications Dose Date Began Reason Prescribed Prescribing Professional

_____

_____

_____

Previous Counseling? Approximate Dates Purpose

_____

_____