aspire
counseling group

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Client Information

Today's date: _____

A. Identification

Your name: _____Date of birth: _____ Age: _____

Home street address: _____ Apt:_____

City: _____ State: _____ Zip: _____

Email address: _____ May we send a message? ☐ Yes ☐ No

Home/evening phone: _____ May we leave a message? ☐ Yes ☐ No

Cell phone: _____ May we leave a message? ☐ Yes ☐ No / May we send a text? ☐ Yes ☐ No

Work phone: _____ May we leave a message? ☐ Yes ☐ No

B. Referral: Who gave you my name to call?

Name: _____

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

D. Your current employer

Employer: _____ Address: _____

Job Title and Duties:_____

How long have you worked with this employer? _____ _____

E. Your education and training

Dates From	To	Schools	Major/specialization?	Adjustment to school	Did you graduate?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

F. Family-of-origin history

Relative	Name	Current age (or age at death)	Illness (or cause of death, if deceased)	Education	Occupation
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Stepparents	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____

G. Marital/relationship history

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated

☐ Divorced ☐ Widowed

Partner's name	Partner's age at cohabitation	Your age at cohabitation	Your age when separated/divorced/widowed
First _____	_____	_____	_____
Second_____	_____	_____	_____
Third_____	_____	_____	_____

H. Children

Name	Birthdate	Sex	School	Grade
_____	_____	_____	_____	____
_____	_____	_____	_____	____
_____	_____	_____	_____	____

I. Health & Mental Health Information

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

☐ Yes ☐ No

Are you currently taking any prescription medication, including anti-depressants, etc.?

□ Yes □ No If yes, please list: _____

Please list any over-the-counter medications or supplements you are currently taking:

_____

Is there any history of physical or emotional trauma that you've experienced?

□ Yes □ No

How would you rate your current physical health?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

How would you rate your current sleeping habits?

□ Poor □ Unsatisfactory □ Satisfactory □ Good □ Very Good

How many times per week do you generally exercise? _____

Please list any difficulties you experience with your appetite or eating patterns.

_____

_____

Are you currently experiencing overwhelming sadness, grief, or depression? □ Yes □ No

Are you currently experiencing anxiety, panic attacks, or have any phobias? □ Yes □ No

Are you currently experiencing any chronic pain? □ Yes □ No

Do you drink more than once per week? □ Yes □ No

How often do you engage in recreational drug use?

□ Daily □ Weekly □ Monthly □ Infrequently □ Never

J. Emergency Information: If some kind of emergency arises, whom should we call?

Name:_____ Phone:_____

Address:_____

Significant other/nearest friend or relative not living with you: _____

K. Financial Information

Insurance company:_____ Phone:_____

Policy #:_____ Group #:_____

Name of Insured (if other than yourself):_____

Address of Insured (if other than yourself):_____

Relationship to Insured:_____ Insured's date of birth:_____

Deductible:_____ Deductible met? □ Yes □ No Co-pay:_____

Coverage limit:_____ Annual sessions limits:_____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.