cohncounseling

Allison R. Cohn, LCSW-C
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CLIENT INFORMATION

Client Name: _____
Date Of Birth: _____
Full Address: _____
_____
_____
E-Mail Address: _____
Home Phone_____
Cell Phone: _____
Work Phone_____
Parent/Guardian Name (if client is minor):
_____
Phone (if different than above): _____

Today's Date: _____
Employer: _____
Occupation: _____
School/Grade (if minor): _____
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐Partnered
Emergency Contact Name: _____
Relationship to Client: _____
Phone_____
Referred by: _____
Phone: _____

WHO LIVES IN YOUR HOUSEHOLD?

Name: _____Age: _____ Relationship: ☐child ☐spouse/partner ☐ Sibling ☐relative
Name: _____Age: _____ Relationship: ☐child ☐spouse/partner ☐ Sibling ☐relative
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Name: _____Age: _____ Relationship: ☐child ☐spouse/partner ☐ Sibling ☐relative

CURRENT SITUATION

Why are you seeking counseling now? _____
_____
Describe the problem: _____
_____
When did it start? _____Who is involved and/or affected by the problem? _____
Have you had previous psychotherapy or counseling? ☐yes ☐no If yes, when? _____
With Whom?_____ How Long was Treatment? _____
Are you currently being prescribed psychiatric medication? ☐yes ☐_no; If yes: What type of medication? _____
Who is the prescribing professional? _____
Have you experienced any MAJOR life changes in the past year (i.e. death, move, job change, relationship stress?) ☐No ☐ Yes
What was the change? _____

MEDICAL HISTORY

Name of Physician_____ Date of Last Physical: _____

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Address: _____ Phone: _____

Current Medications: _____ Allergies: _____

Medical Conditions/Illnesses: _____ May I contact? ☐yes ☐no

How would you describe your health: ☐Poor ☐ Unsatisfactory ☐Satisfactory ☐ Good ☐ Excellent

Are you having problems with your sleep? ☐No ☐ Yes ☐Sleeping too much ☐Sleeping too little ☐Poor sleep quality

(OVER)

How many times per week do you exercise? _____ What type of exercise? _____

Any difficulty with appetite or eating habits? ☐No ☐Yes ☐Eating less ☐Eating more ☐ Binging ☐Restricting

Any significant weight change in the last 2 months? ☐ No ☐ Yes ☐ Gaining ☐ Losing

Do you use alcohol and/or other drugs? ☐ No ☐Yes Are you concerned about your drug and/or alcohol use? ☐Yes ☐No

Have you (or your child) had any suicidal thoughts recently? ☐Never ☐Rarely ☐Sometimes ☐Frequently

Have you (or your child) had any suicidal thoughts or attempts in the past? ☐Never ☐Rarely ☐Sometimes ☐Frequently WHEN?

_____

If there is anything additional that you would like to share, please do so here:_____

_____

_____

_____