Counseling and Behavioral Solutions, Inc.

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Initial Client Information

Today's Date: ____________________________
Name: ____ Date of Birth: _____________________
Address: ____ City: ________________________________
State: ________________ Zip Code: ___________ Referred by: ______________________________________
Gender: M / F Marital Status: _________________________
Phone number: ______________________________ Cell: ___________________________________
Employment: ____
Emergency Contact: ______________________________ Telephone Number: _____________________________
May Emergency Contact be called in an emergency? Yes No
Can you be contacted at either telephone: Yes No, and can a message be left: Yes No
Can a letter be sent to your address if needed: Yes No

Parents/Legal Guardian (if client is a minor):______________________________________
Address: ________________________________ City: _____________________________________ State: _____
Zip Code: ____________________________
Home Telephone: ______________________ Cell: _______________________ Work: ______________________
Date of Birth: ___________________________

Last Physical exam: _______________________________________ Primary Care Doctor: ____________________

Please check behaviors and symptoms that occur to you more often than you would like them to take place:

___ Aggression	____ Elevated mood	____ Phobias/fears
___ Alcohol dependence	____ Fatigue	____ Recurring thoughts
___ Anger	____ Gambling	____ Sexual addiction
___ Antisocial behavior	____ Hallucinations	____ Sexual difficulties
___ Anxiety	____ Heart palpitations	____ Sick often
___ Avoiding people	____ High blood pressure	____ Sleeping problems
___ Chest pain	____ Hopelessness	____ Speech problems
___ Cyber addiction	____ Impulsivity	____ Suicidal thoughts
___ Depression	____ Irritability	____ Thoughts disorganized
___ Disorientation	____ Judgment errors	____ Trembling
___ Distractibility	____ Loneliness	____ Withdrawing
___ Dizziness	____ Memory impairment	____ Worrying
___ Drug dependence	____ Mood shifts	____ Other (specify): _________
___ Eating disorder	____ Panic attacks	____________________________

List any current health concerns: ____
List any recent health or physical changes: ____
____

Please check if there have been any recent changes in the following:

__Sleep Patterns	__Eating patterns	__Behavior	__Energy level
__Physical activity level	__General disposition	__Weight	__Nervousness/tension

Current prescribed medications	Dose	Dates	Purpose	Side effects