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Netting Counseling, LLC
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CONFIDENTIAL CLIENT INFORMATION

Date: _____

Name _____

Address _____

_____

Date of Birth _____ Age _____ Email address:_____

Main Phone_____ circle one: cell home work

Alternate Phone_____ circle one: cell home work

Occupation_____Employer _____

Relationship Status:
☐Single ☐Engaged ☐Married ☐Separated ☐Divorced ☐Widowed ☐Partnered

Previous Mental Health Treatment:
Please list any psychiatrists, therapists, hospitals, self-help groups, and residential treatment centers, and the issues for which you were seen._____

_____

Describe any health concerns: _____

_____

List drugs/medications you presently use and what they are prescribed for: _____

_____

How were you referred to me? (check all that apply)
_____Doctor Referral - _____
(name)
_____Friend/Family - _____
(name)
_____Psychology Today website

_____Yelp

_____Other website _____

Emergency Contact: I require that you give me contact information for a person I can contact in case of emergency and it is to your benefit to do so. This contact will only be used if I believe you or someone else is in immediate danger or if you become ill and unable to continue or depart therapy without assistance.
Emergency Contact's Name:_____ Relationship_____
Address: _____
Phone Number: _____
Please initial your agreement for me to contact the above named person under the above named conditions.
_____

Please describe briefly the concern(s) that bring you here: _____

_____

Please check any of the following items which concern you:

_____ Self-esteem, self-confidence
_____ Anxiety, nervousness, fears
_____ Depression
_____ Sexual concerns
_____ Angry, hostile feelings
_____ Traumatic experience
_____ Physical distress
_____ Eating or appetite problems
_____ Alcohol or drug problems
_____ Sleep problems
_____ Parent-child problems
_____ Other: _____

_____ Family conflicts or pressures
_____ Friendship conflicts
_____ Relationship/marital concerns
_____ Shyness, being assertive
_____ Loneliness
_____ Procrastination or motivation
_____ Gay/Lesbian/Sexuality issues
_____ Suicidal feelings or behaviors
_____ Stress
_____ Self-control
_____ Health problems
_____ Work or career concerns

Please put a *second* check next to those that are of *particular* concern to you right now.

Please list the members of your immediate family (include parents, siblings, spouse / partner, children, and all others in your home):

Name	Relationship	Age	Occupation	Education

FAMILY MENTAL HEALTH HISTORY

If YES, please check the box for all applicable family members

	NO ONE	Mother	Father	Sisters	Brothers	Cousins	Aunt/Uncle	Grandparents
Depression								
Bipolar Disorder								
Anxiety/Panic Disorder								
Eating Disorder								
ADD/ADHD								
Post-traumatic Stress Disorder (PTSD)								
Obsessive-Compulsive Disorder								
Borderline Personality Disorder								
Schizophrenia or Psychosis								
Alcohol or Other Substance Abuse								

Other family mental health information:_____

_____

_____