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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	_____	Family conflicts or pressures
_____	Anxiety, nervousness, fears	_____	Friendship conflicts
_____	Depression	_____	Relationship/marital concerns
_____	Sexual concerns	_____	Shyness, being assertive
_____	Angry, hostile feelings	_____	Loneliness
_____	Traumatic experience	_____	Procrastination or motivation
_____	Physical distress	_____	Gay/Lesbian/Sexuality issues
_____	Eating or appetite problems	_____	Suicidal feelings or behaviors
_____	Alcohol or drug problems	_____	Stress
_____	Sleep problems	_____	Self-control
_____	Parent-child problems	_____	Health problems
_____	Other: ________________________	_____	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, etc):

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:____

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