Curtis Counseling - Client Information

Client: _____ DOB: ___/___/___

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

OK to leave messages? ____Yes ____No

Student?: ___ Yes ___ No ____ Male ____ Female

Referred by: _____

Child lives with: _____ Biological parent/s _____ Relatives _____ Step-parent

_____ Foster care parents Other: _____

IN CASES OF DIVORCE A COPY OF THE PARENTING PLAN IS REQUIRED

Child clients only: _____ Father is deceased _____ Mother is deceased

_____ Parents are divorced _____ Parents are separated

Custodial parent's name: _____

Others who are living in the home (check circle if they are in counseling with client):

Name:	Date of Birth		Relationship	Occupation
_____	___/___/___	O	_____	_____
_____	___/___/___	O	_____	_____
_____	___/___/___	O	_____	_____
_____	___/___/___	O	_____	_____
_____	___/___/___	O	_____	_____

Does anyone above receiving counseling require special accommodation?

___ Yes ___ No If yes, what type?_____

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Medical Information

Current medical problems: _____

_____

Medications: _____

Physicians Name: _____

_____

Check if you decline to sign a release with your doctor _____

Counseling Information

Please place either your initials or those of a family member by problems listed below:

_____ grief issues _____ work-related issues _____ marital issues

_____ divorce issues _____ parenting issues _____ step-family issues

_____ child of divorce _____ alcohol/drug issues _____ eating disorders

_____ physical abuse issues _____ sexual abuse issues _____ sexuality issues

_____ family history of alcohol/drug abuse _____ family history of mental illness

_____ death of family member/significant other _____ serious illness

_____ thoughts of harming someone else _____ thoughts of suicide

_____ past suicide attempts; if so when _____ _____ family issues

Any other relevant information: _____

_____

_____