# Adult/Couples Initial Client Evaluation

Name(s):_____
Address:_____ Birth Date(s): _____
_____

_____ Insurance carrier Birth Date_____

Please give the telephone number in that a voice mail message may be left. Please remember that cellular phones are not necessarily confidential due to technology.

Home:_____Cellular:_____Work:_____

*Someone from our office may be calling from a cellular phone, yet information disclosed will be limited.*

_____**Please initial indicating you understand the limits of confidentiality on cellular phone calls.**

Marital Status: ❒Married _____Yrs ❒Never married ❒Separated
❒Divorced _____Yrs ❒Widowed _____Yrs ❒Engaged

Children: Name_____ Age_____ Live with you: ❒Yes ❒No
Name_____ Age_____ Live with you: ❒Yes ❒No
Name_____ Age_____ Live with you: ❒Yes ❒No
Name_____ Age_____ Live with you: ❒Yes ❒No
Name_____ Age_____ Live with you: ❒Yes ❒No

Parents: Mother's Current Age_____ ❒Deceased Yrs._____ ❒Absent/Unknown
Father's Current Age_____ ❒Deceased Yrs._____ ❒Absent/Unknown
Step-Mother Current Age_____ ❒Deceased Yrs._____ ❒Absent/Unknown
Step-Father Current Age_____ ❒Deceased Yrs._____ ❒Absent/Unknown

Profession/type of work/employment:_____

Years in current field of work: _____ Years in other fields:_____

Highest level of education: ❒Dropped Out ❒High School ❒GED ❒Some College ❒ JD
❒Vocational_____ ❒Bachelors in _____
❒Masters_____ ❒MD_____ ❒PhD_____

Confidential Medical Information:

Do you have any allergies (medication/food/environmental)? ❒No ❒Yes _____

Medical problems:_____
Prescribed medications:_____
Over-the counter medications:_____

In case of a medical or other emergency, please tell us who you would like us to call:

Name:_____ Relationship:_____ Phone:_____

Substance Abuse Information:
Do you feel you have a drug or alcohol problem: ❒Yes ❒No ❒Unsure If yes, why:_____

_____

Counseling Information:
Reason for coming to counseling/desired services:_____
_____

Have you been in treatment or counseling before? ❒Yes ❒No If yes, please give the following info:

Problem:_____Month/Year_____ Center:_____
Were you satisfied with the results: ❒Yes ❒No

Problem:_____Month/Year_____ Center:_____
Were you satisfied with the results: ❒Yes ❒No

Have you had any suicidal or homicidal thoughts now or in the past? ❒Yes ❒No
If yes, when:_____

Did you or have you been thinking about acting on the thoughts? ❒Yes ❒No
Have you ever been mentally, physically or sexually abused? ❒Yes ❒No ❒Unsure
Have you ever mentally, physically or sexually abused someone else? ❒Yes ❒No

What are your goals or expectations for the outcome of this counseling:_____
_____

Client: _____ Date:_____
Clinician: _____Date:_____Time:_____

**Revision: 8/09**