JENNIFER HILL COUNSELING™

CLIENT RECORD- ADULTS

Patient:_____

Date of Birth:_____/_____/_____ *Current Age_____
***If under 18-yrs-old, parental consent needed**

Address: _____ City:_____

State: _____ Zip: _____

Cell Phone: (____) _____ Home Telephone: (____) _____

Work Telephone (____)_____

Sex: Male Female Subscriber S.S.#: _____-_____-_____

Employer/School _____
Job Title/Grade _____
Marital Status: Married Single Divorced Widowed
Partner's Name_____

Emergency
Contact:_____

Telephone:(____) _____

Guardianship Information (if relevant):

Name:_____ Address:_____

Contact Number:_____

Relevant medical conditions (history, current condition, changes in condition):

_____

_____

Medications (dosage, dates of initial prescriptions, name of prescribing professional):

_____

_____

Allergies/adverse reactions to treatment:

_____

_____

Primary Care Physician Name: _____

Telephone _____

Address:_____
City_____ Zip_____

Date of last medical/physical exam:

_____

Reason for seeking therapy:

_____

_____

_____

_____

Treatment Goals:

_____

_____

_____

_____

Past psychological or psychiatric treatment:

_____

_____

Psychiatric hospitalizations (Dates and Locations) :

_____

_____

Family History of psychological or psychiatric treatment

_____

_____

Do you drink coffee? Y or N (#_____cups/daily)
Do you smoke Cigarettes? Y or N (#_____per day)

Alcohol? Y or N (#_____drinks weekly) Date last drank_____
Family History of Alcoholism? Y or N

Marijuana use (past or present) Y or N Date last used_____

Other street drug use (past of present) Y or N
Street drugs: Type_____ Amount _____
Frequency_____ Date last used_____

Police / Probation involvement (past or present) Y or N Date_____
Please explain:

_____

_____

Family Structure (who lives in your household? Please provide names, ages and relationship to each):

_____

_____

_____

_____

Please circle if you have experienced any of the following (past or present):

Domestic Violence Traumas Sexual Abuse Physical Abuse

Sleep Problems Eating Disorders Losses Learning Problems

Suicide Attempts Suicidal Ideation Auditory or Visual Hallucinations

Spending Sprees Outbursts of Anger Lying Fatigue
Phobias

Mood Changes Worry/Fear Panic Attacks Poor Concentration

Tearfulness Feeling Hopeless/Helpless Head Injury or Seizures

What are your strengths

_____

_____

What are your weaknesses

_____

_____

Motivation for treatment

_____

_____

Any other information you believe may be significant

_____

_____

_____

_____

All of the information on page #1, #2, #3, and #4 are true and correct.

Patient's Signature _____

Date _____

Provider's Signature _____

Date _____