

Date: \_\_\_\_\_

# CLIENT INFORMATION

Name		Best Phone Number	Alternate Phone Number	Date of Birth
Street Address		<input type="checkbox"/> Own <input type="checkbox"/> Rent	In case of emergency notify (name, relationship and phone number):	
City	State		Zip	
		<input type="checkbox"/> Never Married <input type="checkbox"/> Living as Married <input type="checkbox"/> First Marriage <input type="checkbox"/> Remarried <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Place of Birth	
Email:		Place of Employment		Education
Would you like to be included on the mailing list for occasional newsletters or presentations by Brian? Y / N (Confidential mailing list is not shared with anyone.)		Type of Work		Annual Household Income
If you surfed the Internet to contact Brian, which website? <input type="checkbox"/> NWTherapyNetwork.com <input type="checkbox"/> AMHA <input type="checkbox"/> Google <input type="checkbox"/> GoodTherapy.org <input type="checkbox"/> Psychology Today <input type="checkbox"/> bhfarr.com		Who told you about Brian Farr? May I thank them? Y / N		
Briefly describe the benefits you want from our counseling sessions: _____ _____				
Your Family / Current Household Members (Spouse/Partner, Children, Step-Children):				
Name	Age	Relationship	Grade/Occupation	Living at home?
_____				
_____				
_____				
Your Family of Origin (Mother, Father, Brothers, Sisters, Step-Siblings):				
Name	Age	Relationship	Occupation	Living within 50 miles?
_____				
_____				
_____				
Who took care of you during the first five years of your life?		Age when you left home?   Reasons for leaving?		
What was your childhood religion and/or sense of spirituality?		Military Service?   Approximate Dates?   Combat Duty?		
Current physical problems or complaints?		How much do you consume in an average day? Caffeine:                      Alcohol:                      Tobacco:		
Current prescription medications?		Have you seen another psychotherapist in the past two years?   Name(s)?		
Please check <input type="checkbox"/> your current concerns and <u>underline</u> your historical issues.   When was your most recent physical exam? _____				
<input type="checkbox"/> Fatigue <input type="checkbox"/> Grief/Loss <input type="checkbox"/> Feelings of Hopelessness <input type="checkbox"/> Crying Spells <input type="checkbox"/> Depression <input type="checkbox"/> Thoughts of Hurting Yourself <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Anxiety <input type="checkbox"/> Excessive Energy <input type="checkbox"/> Anger <input type="checkbox"/> Feeling Out of Control <input type="checkbox"/> Unusual Weight Gain/Loss <input type="checkbox"/> Survivor of Emotional or Physical Abuse/Trauma <input type="checkbox"/> Addictive Behaviors <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Sexual Activity <input type="checkbox"/> Sleeping Too Much or Too Little <input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Personal Finances <input type="checkbox"/> Bankruptcy <input type="checkbox"/> Other:				