Hope and Healing of Pinellas

Client Information Form 1

Today's date: __________________

A. Identification
Your name: ____ Date of birth: ____________ Age: ____
SS#______________________
Children(s) names that will receive counseling _______________________________________ Child DOB_________
Home street address: ____ Apt.: __________
City: ____ State: _____ Zip: _____________
Primary phone: ________________________________ e-mail: ____
Calls or e-mail will be discreet, but please indicate any restrictions: ____
Check here to consent to texting to confirm or cancel appointments_____

B. Referral: Who can we thank for referring you?
Name: ____ Phone: ___________________________
Address: ____
May I have your permission to thank this person for the referral? ❑ Yes ❑ No

D. Mental Health Providers:
Are you currently seeking another therapist of psychiatrist?

Therapist/doctor's name: ____ Phone: ________________________
Medications:____
_
Any mental health diagnosis you wish to share with
us____

E. Your current employer
Employer: ____
Work phone: _______________________________
Can we call this number? Y___ N____

F. Emergency information
If some kind of emergency arises and we cannot reach you directly, whom should we call?
Name: ___________________________________ Phone: _____________________ Relationship: _________________
Address: ____

G. Your education and training
Highest level of education: ________________________________

H. Military experiences:____

I. Family-of-origin history:

Please include any family history your feel would be helpful for us to know: i.e. parents, divorce, addiction, abuse that will be helpful for the therapist to know:

J. Marital/relationship history:

K. Children: (name, DOB, medical/psychological concerns, grade in school)

L**. Is there any other information you'd like to share that will help us to help you?**

Thank you for taking the time to complete this form

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.