



CLIENT INFORMATION

Full Name _____ Age _____ Gender (as you identify) _____

Preferred Name _____ E-mail _____

Address _____ City _____ State _____ Zip _____

Phone (h) _____ (c) _____ Check preferred

Social Security Number _____ Date of Birth _____

Married Single Widowed Divorced Separated

Spouse (Partner) _____ Age _____

Working Disabled Retired

Medical Conditions

Medications

Physician (primary) _____ Address _____ Phone _____

Physician (specialist) _____ Address _____ Phone _____

Have you ever had counseling or therapy before? Yes No If yes, please give approx. dates and with whom

May we contact former counselor/ therapist? Yes No Are you currently under psychiatric care? Yes No

If yes, Psychiatrist Name _____

Address _____ Phone _____

Are you currently taking any psychotropic medications? Yes No If yes, please list

What led you to Solace Health Partners? Insurance/EAP Internet Search Physician Phone Book Friend

Other _____

What problems or issues are you having that caused you seek counseling/therapy?

Have you ever attempted suicide or had serious suicidal thoughts? Yes No If yes, are you having suicidal

thoughts now? Yes No Have you ever been hospitalized for a mental condition? Yes No If yes, when did this occur and where?

Emergency Contact _____ Phone _____

Signed _____ Date _____