SOLACE HEALTH PARTNERS
TIME FOR YOU, IN YOUR TIME

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 (please list dosage and frequency)

_____

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 _____

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