

Aspire Counseling Group, PLLC



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Client Information

Today's date: _____

Note: If you have been a client here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Home street address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Email address: _____ May we send a message? Yes No

Would you be interested in receiving a newsletter/blog from us from time to time? Yes No

Home/evening phone: _____ May we leave a message? Yes No

Cell phone: _____ May we leave a message? Yes No

Work phone: _____ May we leave a message? Yes No

B. Referral: Who gave you my name to call?

Name: _____

May I have your permission to thank this person for the referral? Yes No

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

D. Your current employer

Employer: _____ Address: _____

Job Title and Duties: _____

How long have you worked with this employer? _____

E. Your education and training

| Dates | | Schools | Major/specialization? | Adjustment to school | Did you graduate? |
|-------|-------|---------|-----------------------|----------------------|-------------------|
| From | To | | | | |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

F. Family-of-origin history

| Relative | Name | Current age (or age at death) | Illness (or cause of death, if deceased) | Education | Occupation |
|-------------|-------|-------------------------------|--|-----------|------------|
| Father | _____ | _____ | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ | _____ | _____ |
| Stepparents | _____ | _____ | _____ | _____ | _____ |
| Brothers | _____ | _____ | _____ | _____ | _____ |
| Sisters | _____ | _____ | _____ | _____ | _____ |

G. Marital/relationship history

Marital Status: Never Married Domestic Partnership Married Separated
 Divorced Widowed

| Partner's name | Partner's age at cohabitation | Your age at cohabitation | Your age when separated/divorced/widowed |
|----------------|-------------------------------|--------------------------|--|
| First _____ | _____ | _____ | _____ |
| Second _____ | _____ | _____ | _____ |
| Third _____ | _____ | _____ | _____ |

H. Children

| Name | Birthdate | Sex | School | Grade |
|-------|-----------|-------|--------|-------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

I. Health & Mental Health Information

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
 Yes No

Are you currently taking any prescription medication?

Yes No If yes, please list: _____

Have you ever been prescribed psychotropic medication?

Yes No If yes, please list: _____

How would you rate your current physical health?

Poor Unsatisfactory Satisfactory Good Very Good

How would you rate your current sleeping habits?

Poor Unsatisfactory Satisfactory Good Very Good

How many times per week do you generally exercise? _____

Please list any difficulties you experience with your appetite or eating patterns.

Are you currently experiencing overwhelming sadness, grief, or depression? Yes No

Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes No

Are you currently experiencing any chronic pain? Yes No

Do you drink more than once per week? Yes No

How often do you engage in recreational drug use?

Daily Weekly Monthly Infrequently Never

J. Emergency Information: If some kind of emergency arises, whom should we call?

Name: _____ Phone: _____

Address: _____

Significant other/nearest friend or relative not living with you: _____

K. Financial Information

Insurance company: _____ Phone: _____

Policy #: _____ Group #: _____

Name of Insured (if other than yourself): _____

Address of Insured (if other than yourself): _____

Relationship to Insured: _____ Insured's date of birth: _____

Deductible: _____ Deductible met? Yes No Co-pay: _____

Coverage limit: _____ Annual sessions limits: _____

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