Judy Hait, LMFT, PLLC

Counseling for Individuals & Couples AAMFT Approved Supervisor

CLIENT INFORMATION

Please fill out this form for all family members and people living in the home.

Date: ____________________

1. Client Name: ____________________ Birthday (M/D/Y): ____________

   E-mail: ____________________

   Phone: Cell: ____________ Home: ____________ Work: ____________

   Street Address: ____________________

   City/State/Zip: ____________________

   Sex: ☐ Male: ☐ Female: ☐ Other:

   Relationship Status ☐ Single ☐ Married or Partnered ☐ Divorced ☐ Dating ☐ Other

2. Name: ____________________ Birthday (M/D/Y): ____________

   E-mail: ____________________

   Phone: Cell: ____________ Home: ____________ Work: ____________

   Street Address: ____________________

   City/State/Zip: ____________________

   Sex: ☐ Male: ☐ Female: ☐ Other:

   Relationship Status ☐ Single ☐ Married or Partnered ☐ Divorced ☐ Dating ☐ Other

Others living in home:

Name: Age: Relationship:

3. ____________________

4. ____________________

5. ____________________

5508 234th St SW, Mountlake Terrace, WA 98043 ▪ (206) 233-3693 ▪ fax: (425) 670-2526 ▪ www.judyhait.com

Have you or anyone in your family had prior counseling? (include hospitalizations)

Name of Client	Where/Who	For help with	Length of Treatment

Was it helpful? Why? Why not?

____

Describe any major medical problems: ____

____

Medications, what they are for and dosage: ____________________________________

____

Doctor's Name: ________________________________ Phone Number: _______________

Doctor's Address: ____

Please let me know if you have more than one doctor.

Who should I contact in an emergency? ___________________ Phone Number: _______________

What is their relationship to you? ____

Check any problems that apply to your reason for seeking treatment:

___ Relationship Problems
___ Self Esteem
___ Withdrawn Behavior
___ Sleep Problems
___ Nightmares
___ Eating Problems, what kind? _____________
___ Difficulty Getting Pregnant
___ Legal Difficulties
___ Sexual Problems
___ Chronic Pain, what kind? _______________
___ Depression, Sadness
___ Financial Concerns
___ Blended Family Issues
___ Divorce/Separation
___ Anxiety
___ Anger
___ Attention Differences (ADD/ADHD)
___ Repetitive Thoughts (thinking about the same thoughts over and over again)
___ Other (describe): ______________________________
___ Panic Attacks
___ Sexual Abuse
___ Physical Abuse
___ Alcohol/Drug Abuse (client)
___ Alcohol/Drug Abuse (other person)
___ Work Issues
___ HIV/AIDS
___ Peer Problems
___ Children Moving Out
___ Stress
___ Death of a Loved One (include pets)
___ Other Losses
___ Health Concerns
___ Life Transition Issues
___ Suicidal Thoughts
___ Suicidal Actions
___ Recent Move
___ Sexual Orientation Questions

How long have symptoms been present? (weeks, months, years**)** ___________________________

Why are you seeking help at this time? ____

____

Have you or a family member had a problem with alcohol or drugs in the past year? Y/N

Your alcohol consumption: _____drinks per day of ____________
_____drinks per week of ___________

Please list all drugs you have used in the past year:

____

____

What, if any, family history is there of problems with drugs and alcohol? __________________________________

____

Exercise: how often, what type, if any ____

Sleep: no problems, trouble falling asleep, trouble staying asleep, not feeling rested, getting less than 6 hrs a night. (Circle any that apply). Other_________________________

Please tell me briefly about your family, names and order of sibling, history of problems with alcohol and drugs, major medical services, recent changes, etc.:

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Who referred you to me? ____OK to thank? ☐ Yes ☐ No

Their phone number or address: ____