Confidential Client Information Form

R. Davenport LCSW, PA

Client Name: _____ **Date:** _____

Address: _____ _____

State/Zip: _____ **Counselor:** _____

Email: _____ **Cell / TXT:** _____

Ok to send? **Yes** **No** Ok to txt/call? **Yes** **No**

Work phone: _____ **Other Contact:** _____

Date of Birth: _____ **Employer:** _____

Age: _____ **Start Date:** _____

Pronouns: _____ **Insurance:** _____

Relationship: _____ **Policy Number:** _____

Education: _____ **Ins telephone:** _____

Referral Source: How did you hear about my practice?

☐ Previous Contact ☐ Friend/Colleague ☐ Insurance list ☐ Web Page ☐ Brochure/Flyer ☐ Business Card ☐ Newspaper Ad ☐ Seminar

- Please list the names and ages of people that currently live in your household:

_____

- Please list the names and ages of any of your children not listed above:

_____

- May I send correspondence to your home address/ email /text your cell? **Yes No.** Alternative address: _____

- Have you had any previous contact with me? **Yes No** Are you, or is any member of your family **currently** receiving services here? **Yes No** If yes for either of these questions, please describe when and in what circumstance.

_____

_____

- Are you seeing a therapist now or have you seen one in the past? **Yes No**

  Please describe: _____

_____

- Please list any medications, recreational drug(s) or alcohol that you use/have used:

_____

_____

- Who may I contact in case of an emergency?

  Name: _____

  Phone: _____ Relationship: _____

(OVER PLEASE)

- Please explain briefly what brings you to counseling.

- What are your **goals** in seeking assistance?

- Do you consider yourself to be in crisis? **Yes No**

- Have you ever tried to hurt or kill yourself? **Yes No**
- Do you have any suicidal thoughts or feelings now? **Yes No (if yes to either, please describe).**

Please read this checklist and check items that are of current concern in your life:

Abortion		Legal Matters	
Adoption		Loneliness	
Anger		Loss/grief	
Anxiety		Parenting	
Battering		Physical Complaints	
Childhood Abuse		Rape	
Crisis		Relationship	
Depression		Sexual Abuse	
Divorce/Separation		Sexuality	
Drugs/Alcohol		Suicidal Thoughts	
Eating prob.		Therapist Referral	
Employment		Unplanned Pregnancy	
Financial		Violence	

Other: _____

- Have you ever been convicted of a felony? **Yes No** Are you currently involved and/or have a history in the legal system (child custody, divorce, DWI, probation, parole, etc.)? **Yes No**

- Please briefly describe your job duties and working conditions: (e.g.: job title, how long with this company, safety issues, deadline pressures, typical number of hours you work a week, etc.)

- Have you or any member of your family experienced emotional problems/ illness or drug or alcohol dependency or abuse?

- Is there anything else I should know about you or your situation?