Nichols Counseling
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Adult Client Information Form

Today's date: _____ **Client #**_____
Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification
Your name: _____Date of birth: _____ Age: _____
Nicknames or aliases: _____ Social Security #: _____
Home street address: _____ Apt.:_____
City: _____ State: _____Zip: _____
Home/evening phone: _____ Calls will be discreet, but please indicate any restrictions:_____
_____

B. Referral: Who referred you to my office?
Name: _____ Phone: _____
Address: _____
_____
May I have your permission to thank this person for the referral? ☐ Yes ☐ No
How did this person explain how I might be of help to you? _____
_____
_____

C. Your medical care: From whom or where do you get your medical care?
Clinic/doctor's name: _____ Phone: _____
Address: _____
If you enter treatment with me for therapy, may I tell your medical doctor so that he/she can be fully informed and we can coordinate your treatment? ☐ Yes ☐ No
In the event of an emergency, may I contact your medical doctor and disclose necessary information so that he/she can be fully informed and we can coordinate your treatment? ☐ Yes ☐ No

D. Your current employer
Employer: _____ Address: _____
_____
Work phone: _____Calls will be discreet, but please indicate any restrictions: _____
_____

E. Marital History
Are you: Single_____Married_____Divorced_____Widowed_____Never Married_____
If you are married, how long have you been married?_____
If you are divorced, give the month and year that your divorce was granted_____
If you are remarried following divorce/death of spouse, give the date of the marriage_____
Are you currently separated from your spouse? _____ Yes _____ No
Are you contemplating separation or divorce? _____ Yes _____ No
Do you have children? _____ Yes _____ No
If so, please list their names and ages:_____
_____

F. Family Members (list those living in home with you):

Name	Age	Sex	Grade	Relationship to You
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

G. Medications:

Name of Medication? Dosage/Mg? Frequency?

_____
_____
_____
_____

H. Any problems or concerns about your medications? _____ Yes _____ No
(If yes have you talked to the prescribing physician? _____

I. Emergency Contacts

List the name(s) of the person(s) who may be contacted by this office in the event of an emergency. Please be aware that the persons listed may receive information in an emergency situation that would otherwise be confidential by law. By listing the name(s) below, you give this office permission to contact the person(s) listed and provide necessary information about you in the event of an emergency.

_____
_____
_____

J. Chief Concern(s): Please describe the main difficulty that has brought you to see me: _____

_____
_____
_____

K. Have you ever received counseling services before? __No __Yes. If yes,

When? With Whom? For What? With What results?

_____
_____
_____

L. Abuse History? _____I was not abused in any way. _____I was abused (sexual, physical, emotional, neglect) If you were abused:

Age of Abuse Who did it? Whom did you tell? Consequences of telling?

_____
_____
_____

M. Health

List all illnesses, hospitalizations, medications, allergies, head trauma, important accidents and injuries, surgeries, periods of loss of consciousness, convulsions/seizures, and other relevant medical conditions.

Condition	Age	Treated by whom?	Consequences?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

N. Residences Outside your home**?** (Examples would be Foster Care, Residential Placement, etc) **____ No ___Yes** (If yes please complete below):

From	To	Location	Reason for moving	With whom	Any problems?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

O. Education

Schools attended (Name and location)	Degree/Level Completed	Date Completed
_____	_____	_____
_____	_____	_____
_____	_____	_____

(Office Use Only) Insurance Information:

Name of Insurance Company: _____ Effective date of coverage: _____
Policy ID #:_____ Group #:_____ SSN#:_____
Policy Holder Name: _____ Date of Birth of Policy Holder _____
Policy Holder Employer:_____ Phone Number: _____
Authorization/Certificate #_____ Beg and End Dates: _____
Of Authorized Visits: _____ **Benefits**: Deductible: _____ Co Pay: ____ #Visits per year: _____