ArborGate Associates, Inc.

CLIENT CONFIDENTIAL INFORMATION FORM

CLIENT LAST NAME	FIRST NAME		MIDDLE INITIAL	DATE
STREET ADDRESS				BIRTHDATE
CITY	STATE	ZIP		SOCIAL SECURITY NUMBER
EMPLOYER				HOME PHONE
OCCUPATION				WORK PHONE
MARITAL STATUS	EDUCATION ❑ HIGH SCHOOL ❑ COLLEGE			CELL PHONE
SPOUSE LAST NAME	FIRST NAME		MIDDLE INITIAL	BIRTHDATE
ADDRESS, IF DIFFERENT				SOCIAL SECURITY NUMBER
EMPLOYER				HOME PHONE
OCCUPATION				WORK PHONE
EMERGENCY CONTACT: NAME			RELATIONSHIP	
ADDRESS, IF DIFFERENT				PHONE
RESPONSIBLE PARTY ❑ SELF ❑ PARENT/GUARDIAN ❑ SPOUSE ❑ OTHER (SPECIFY)				
INSURANCE COMPANY				SOCIAL SECURITY NUMBER
NAME OF SUBSCRIBER				I.D. NUMBER
ADDRESS OF INSURANCE COMPANY				PHONE INSURED'S DATE OF BIRTH
CO-INSURANCE COMPANY				GROUP NUMBER
NAME OF SUBSCRIBER				I.D. NUMBER
ADDRESS OF CO-INSURANCE COMPANY				PHONE INSURED'S DATE OF BIRTH
WHO REFERRED YOU TO ARBORGATE ASSOCIATES, INC. ?				
NAME				PHONE
ORGANIZATION				

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CLIENT COUNSELING HISTORY

NAME OF PREVIOUS COUNSELOR	PHONE
ADDRESS	
HAVE ANY OF YOUR FAMILY MEMBERS HAD COUNSELING BEFORE? IF SO, FOR WHAT?	
BRIEFLY DESCRIBE WHY YOU ARE SEEKING COUNSELING AT THIS TIME	
PLEASE STATE WHAT YOU HOPE TO ACHIEVE THROUGH COUNSELING	
OTHER INFORMATION YOU MIGHT WANT TO ADD	

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CLIENT FAMILY HISTORY FORM

FATHER'S NAME			AGE
MOTHER'S NAME			AGE
NUMBER OF BROTHERS	NUMBER OF SISTERS	WHERE ARE YOU IN THE BIRTH ORDER?	
SPOUSE'S NAME			AGE
CHILDREN'S NAMES			AGE
			AGE
			AGE
			AGE

CLIENT MARITAL STATUS

❑ SINGLE ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED (HOW LONG)_____ ❑ MARRIED

IS THERE ANY HISTORY OF DRUG OR ALCOHOL ABUSE (AGE 11 AND OVER)?

❑ FATHER'S FAMILY ❑ MOTHER'S FAMILY ❑ SELF/SPOUSE

PLEASE DESCRIBE:

IS THERE ANY CURRENT DRUG, ALCOHOL OR TOBACCO SUBSTANCE ABUSE (AGE 11 AND OVER)?

❑ FATHER'S FAMILY ❑ MOTHER'S FAMILY ❑ SELF/SPOUSE

PLEASE DESCRIBE:

IS THERE ANY HISTORY OF PHYSICAL OR SEXUAL ABUSE TO YOU, BROTHERS, OR SISTERS?

❑ YES ❑ NO

PLEASE DESCRIBE

ARE THERE ANY LEGAL JUDGEMENTS PENDING OR PREVIOUS CRIMINAL CONVICTIONS?

❑ YES ❑ NO

PLEASE INDICATE PERSON(S) INVOLVED AND BRIEFLY DESCRIBE

PLEASE NOTE ANY OTHER COMMENTS THAT YOU FEEL MIGHT BE IMPORTANT TO THIS COUNSELING PROCESS

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CLIENT MEDICAL INFORMATION

FAMILY PHYSICIAN	PHONE
ADDRESS	DATE OF LAST COMPLETE PHYSICAL EXAM
PSYCHIATRIST	PHONE
ADDRESS	DATES SEEN

ARE YOU TAKING ANY PRESCRIPTION DRUGS AT THIS TIME?

❑ YES ❑ NO

IF YES, THEN WHAT TYPE, FOR WHAT PURPOSE, AND PRESCRIBED BY WHOM?

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS?

❑ YES ❑ NO

IF YES, LIST MEDICATION AND DESCRIBE REACTION

HAVE YOU HAD ANY RECENT SURGERY OR TREATMENT FOR ANY ILLNESS WITHIN THE LAST YEAR?

❑ YES ❑ NO

IF YES, EXPLAIN

PREVIOUS HOSPITALIZATIONS?

❑ YES ❑ NO

REASON

PLEASE INDICATE ANY ACCIDENTS / CIRCUMSTANCES AND DATES:

DO YOU NOW HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (CHECK ALL THAT APPLY)

❑ Eating disorder/ bulimia and anorexia	❑ Attention deficit disorder	❑ Kidney problems
❑ Irritable bowel syndrome	❑ Panic attacks	❑ Lupus
❑ PMS / menopause	❑ Hyperthyroidism / hypothyroidism	❑ High blood pressure
❑ Alzheimer's / dementia	❑ Hypoglycemia / diabetes	❑ Multiple sclerosis
❑ Learning disabilities	❑ Allergies / candida	❑ Arthritis
❑ Depression	❑ Infectious mononucleosis	❑ Heart disease
❑ Severe anxiety	❑ Anemia	❑ Ulcers
❑ Sleep difficulty	❑ Cancer	❑ Epilepsy / seizures
❑ Headaches	❑ Asthma	❑ AIDS or HIV+

HOW HAVE THESE PROBLEMS AFFECTED YOUR LIFE?