CRANE COUNSELING, LLC
7313 Millwood Road
Bethesda, MD 20817
Office: 301.370.9794
www.cranecounselingllc.com
EIN 45-2263500

CLIENT INFORMATION

Client Name: _____
Date Of Birth: _____
Full Address: _____
_____
_____
E-Mail Address: _____
Home Phone_____
Cell Phone: _____
Work Phone_____
Best way to Reach You _____
Parent/Guardian Name (if client is minor):
_____
Phone (if different than above): _____

Today's Date: _____
Employer: _____
Occupation: _____
School/Grade (if minor): _____
Marital Status: ☐Married ☐Single ☐Divorced
☐Widowed ☐Partnered
Emergency Contact Name: _____
Relationship to Client: _____
Phone_____
Referred by: _____
Phone: _____

Who lives in your household?: (Pls alsoList other children NOT living at home separately here)

Name: _____ Age: - _____ Relationship: ☐child ☐spouse/partner ☐ Sibling ☐relative
Name: _____ Age: _____ Relationship: ☐child ☐spouse/partner ☐ Sibling ☐relative
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REASON FOR TREATMENT

Why are you seeking counseling now?

_____
_____
Describe the problem: _____
When did it start? _____
Who is involved and/or affected by the problem? _____
_____
GOALS for THERAPY (What do you want to focus on?)
_____
_____

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Have you had previous psychotherapy or counseling? ☐yes ☐no If yes, when? _____
With Whom?_____ How Long was Treatment? _____
Are you currently being prescribed psychiatric medication? ☐yes ☐_no; If yes: What type of medication(s)?

_____

Who is the prescribing professional? _____
Have you experienced any MAJOR life changes in the past year (i.e. death, move, job change, relationship stress?) ☐No
☐ Yes, If yes, what is it/are they?_____
Alcohol/Drug Use? Frequency currently/past substance use? _____

In a typical week, how often do you have 3 or more drinks in 24 hr. period

_____

Family History of Mental Illness or Substance Abuse

Childhood History of Trauma or Abuse

Adult History of Trauma or Abuse?

MEDICAL HISTORY

Name of Physician_____ Date of Last Physical: _____
Address: _____ Phone: _____
Current (non-mental health) Medications: _____ Allergies:

_____

Medical Conditions/Illnesses: _____ May I contact? ☐yes ☐no
How would you describe your health: ☐Poor ☐ Unsatisfactory ☐Satisfactory ☐ Good ☐ Excellent
Are you having problems with your sleep? ☐No ☐ Yes ☐Sleeping too much ☐Sleeping too little ☐Poor sleep quality ☐Disturbing dreams
How many times per week do you exercise? _____ What type of exercise? _____
Any difficulty with appetite or eating habits? ☐No ☐Yes ☐Eating less ☐Eating more ☐ Binging ☐Restricting
Any significant weight change in the last 2 months? ☐ No ☐ Yes ☐ Gaining ☐ Losing
Have you (or your child) had any suicidal thoughts recently? ☐Never ☐Rarely ☐Sometimes ☐Frequently

CLIENT SIGNATURE: **DATE:**

_____ _____