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CLIENT INFORMATION
(Section I)
ALL INFORMATION REMAINS STRICTLY CONFIDENTIAL

Date: _____

Your Name: _____

Address: _____City_____

St. and Zip: _____E-Mail: _____

Telephone numbers:

H): _____O): _____C): _____

Is it okay to contact you at work? _____Yes _____No

Is it okay to contact you at home? _____Yes _____No

Employer: _____ Job Title: _____

Gender: _____Sexual Orientation: _____

Birth Date: _____

Referral Source: (please check one)

____Friend **____Current or former client**

____Web Site **____Doctor. Dr. Name_____**

____Dallas Voice **____Attorney. Name: _____**

_____Other_____

Emergency Contact Name, Phone Number and relation to you:

Partner and Marital Status (please check one):

____Single **____Married**

____Committed Relationship Living Together **____Widowed**

____Committed Relationship Not Living Together **____Divorced**

____Separated

Spouse/Partner's Name: _____

Children? **_____Yes** **_____No**

If yes:	**Name of Children**	**Date of Birth**	**Lives with you?**

CLIENT INFORMATION
(Section II)

PLEASE ANSWER THE FOLLOWING. <u>YOUR ANSWERS SHOULD BE BRIEF</u>

Describe your reasons for contacting me or what kind of problem are you experiencing?

How long has this been a problem for you?

Please describe prior counseling or treatment you have had.

Was it helpful? Why or why not?

What other ways have you tried to handle this problem?

On a scale of one to five, how serious is your problem? Pls. Circle a number.

Not very serious very serious

1 2 3 4 5

How has this problem affected your (please circle number which applies):

	Does Not Apply	Not At All				Very Much
Partner/Marriage?	____	**1**	**2**	**3**	**4**	**5**
Family?	____	**1**	**2**	**3**	**4**	**5**
Job/School Performance?	____	**1**	**2**	**3**	**4**	**5**
Friendships?	____	**1**	**2**	**3**	**4**	**5**
Financial Situations?	____	**1**	**2**	**3**	**4**	**5**
Legal Situations?	____	**1**	**2**	**3**	**4**	**5**
Health?	____	**1**	**2**	**3**	**4**	**5**
Anxiety Level/Nerves?	____	**1**	**2**	**3**	**4**	**5**
Mood?	____	**1**	**2**	**3**	**4**	**5**
Eating Habits?	____	**1**	**2**	**3**	**4**	**5**
Sleeping Habits?	____	**1**	**2**	**3**	**4**	**5**
Ability to Concentrate?	____	**1**	**2**	**3**	**4**	**5**
Ability to Control Temper?	____	**1**	**2**	**3**	**4**	**5**
Spirituality?	____	**1**	**2**	**3**	**4**	**5**

Have you ever felt like you should cut down on your alcohol or other drug use (including prescription drugs)?

_____Yes **____No**

Has a friend or relative discussed concerns about your alcohol or drug use?

____Yes **____No**

Have you ever felt guilty about your drinking or drug use?

____Yes **____No**

Have you ever had to take a drink or use a drug the next day to steady your nerves?

____Yes **____No**

Are you a recovering alcoholic or recovery drug addict?

____Yes **____No**

Is there a history of problems with alcohol or drug use in your family?

____Yes **____No**

Have you ever used alcohol or drugs before or during school or work?

____Yes **____No**

Have you ever missed school or work because of use or just to use?

____Yes **____No**

Have you ever avoided non-users?

____Yes **____No**

About how often do you get intoxicated?

About how often do you use more than one drug when you get intoxicated?

Please list any over the counter and prescription drugs you are currently using.

Describe any medical problems (i.e. any serious illness you have or have had, any injuries, etc.).

When was your last physical? Please describe any significant results of your physical.

What do you hope to accomplish by coming here?

Thank you for taking the time to complete this form!