KATHRINE ANDERSON
COUNSELING
MENTAL AND BEHAVIORAL HEALTH SERVICES

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Client Information and Health Form

Client Information:

Client Name/s: _____ Date: _____

Address: _____City: _____State: ____ Zip: _____

Date of Birth: _____

Home Phone: _____Cell: _____Work: _____

Email Address: _____

Employer/School: _____Address:_____

Responsible Party (If client is under 15 YO):

If you are the parent or legal guardian of a client who is under the age of 15, please complete the following with your information. If you are over the age of 15, please proceed to the next section.

Name of Parent(s) or Legal Guardian(s):_____

Address: _____ City: _____State: ____ Zip: _____

Date of Birth: _____

Home Phone: _____Cell: _____Work: _____

Email Address: _____

Employer/School: _____Address:_____

Emergency Contact Information:

Name: _____Relationship to Client: _____

Address: _____ City: _____State: ____ Zip: _____

Home Phone: _____Cell: _____Work: _____

Health:

1. Please describe your present level of health._____

   _____

2. Any current health complaints? _____

   _____

3. Have you been diagnosed with any medical condition? _____

   _____

4. When was your last physical? _____

   _____

5. What medications do you currently take (prescription, over the counter or "street drugs")?

   _____

6. Has there been any changes in sleep pattern or appetite? _____

   _____

7. Do you exercise? If so, how much and how often? _____

   _____

8. Do you consume alcohol? If so, how much. How often? _____

   _____

9. Any major life changes in the last year? _____

   _____

Name of Physician:

Name: _____ Phone: _____

Name of Psychiatrist: (if applicable)

Name: _____ Phone: _____

Who Were You Referred By?

Name: _____

Family Mental Health History:

The following is to provide information about your family history. Please mark each a yes or a no. If yes, please indicate the family member affected.

Depression	Yes/No	Family member: _____
Anxiety Disorder	Yes/No	Family member: _____
Bipolar Disorder	Yes/No	Family member: _____
Panic Attacks	Yes/No	Family member: _____
Alcohol/substance abuse	Yes/No	Family member: _____
Eating disorder	Yes/No	Family member: _____
Learning disability	Yes/No	Family member: _____
Trauma history	Yes/No	Family member: _____
Domestic violence	Yes/No	Family member: _____
Obsessive/compulsive behavior	Yes/No	Family member: _____
Schizophrenia	Yes/No	Family member: _____

Other: _____