Finding BALANCE, LTD.

CONFIDENTIAL CLIENT INFORMATION

Patient's Name: ______________________________________ ______________

First Middle Last Social Security

Marital Status: ○ Single ○ Married ○ Divorced ○ Separated ○ Widowed ○ Other: ______________

Current Occupation: ______________________ Age: ________ Number of Children: ____________

Spouse Name: ______________________ Occupation of Spouse: ____________ Years Married: _____

CHILDREN INFORMATION:	Name of Child	Sex	Age

SIBLING INFORMATION: Please list in birth order – including yourself in the order	Name of Sibling/Self	Sex	Age

Were you raised by: ○ Both Parents ○ Single Parent ○ Relative ○ Other: ______________________

Is there a family history of:: ○ Alcoholism ○ Substance Abuse ○ Mental Illness: ○ Prolonged Physical Illness

Current Medications:

Significant Medical Problems/History:

Have you had previous psychiatric care and/or counseling? ○ Yes ○ No Type and Diagnosis: ______________

If yes, please provide:
Name of Clinician: ______________________ Session dates: from ____________ to ____________

Have you ever been hospitalized for substance abuse, alcoholism, eating disorders, or psychiatric disorders: ○ Yes ○ No
If yes, please provide details: