Jesús E. Reyes, L.C.S.W.

Client Information Form

Name: _____ Date of Birth: _____ Date: _____

Home address: _____

E-mail address:_____

Telephones: Home: _____ Cell: _____ Date of birth: _____ Age: _____

Highest grade completed/degree: _____ Profession/Occupation: _____

Emergency contact (name, relationship, telephone number): _____

Active Insurance Coverages:

Primary Insurance	Subscriber Name	Subscriber Number	Group Number
_____	_____	_____	_____
Secondary Insurance	**Subscriber Name**	**Subscriber Number**	**Group Number**
_____	_____	_____	_____

What brings you to therapy? _____

_____

_____

_____

_____

_____

Medical/Psychiatric physician(s):

Name and Specialty	Address and telephone	Last exam date:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Present and past medical care and dates (major problems, accidents, hospitalizations, current medication):

_____

_____

_____

_____

_____

_____

_____

_____

PAST/PRESENT COUNSELING/PSYCHOTHERAPY/MENTAL HOSPITALS:

1. Hospital or Therapist: _____ Dates: _____ to _____

Address: _____ Phone: _____

Initial reason: _____

_____

Treatment and outcome: _____

_____

2. Hospital or Therapist: _____ Dates: _____ to _____

Address: _____ Phone: _____

Initial reason: _____

_____

Treatment and outcome: _____

_____

Other present/past drug/alcohol use/abuse (involvement in AA/NA, etc.):

_____

_____

_____

_____

Family history of alcoholism or other substance abuse, mental illness, violence, suicide: _____

_____

_____

_____

_____

Please use the back of this form to add further information on any item above or other relevant information.