



**C. Blair Skinner**, M.S.  
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## Client Information Form

### Client Identification: Please give information for primary client

Client Name			Today's Date
Street Address			Date of Birth
City	State	Zip Code	Age
Home Phone	Work Phone	Cell Phone	
Is it OK to call and leave messages at these phone numbers? If not please indicate any restrictions:			
Employer/School	Address	Occupation/Grade Level	
Relationship Status: ( ) Never Married ( ) Married ( ) Married/Separated ( ) Widowed ( ) Divorced			

### Parent Identification (If primary client is a child):

Mother's Name	Date of Birth
Occupation	Phone (if different from above)
Father's Name	Date of Birth
Occupation	Phone (if different from above)
Step-Parent / Caregiver Name & phone if different from above	Relationship to client
Step-Parent / Caregiver Name & phone if different from above	Relationship to client

### Referral Information: Please tell me how you got my name, or who referred you to me

Name / Source	Phone
May I have your permission to thank this person for the referral? ( ) Yes ( ) No	

### Previous Mental Health Treatment History

Date(s)	Provider	Purpose
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**Household Information: Please list other family members or significant people living in your home**

Name	DOB / Age	Gender	Relationship to client
Name	DOB / Age	Gender	Relationship to client
Name	DOB / Age	Gender	Relationship to client

**Medical History Information: Please give primary client's information**

Are you currently taking prescription medications? ( ) Yes ( ) No If so, please list names and dosages:			
Are you currently taking non-prescription medications? ( ) Yes ( ) No If so, please list names and dosages:			
Do you smoke? If yes, how much?	Do you drink alcohol? If yes, how much?		
<b>Except as prescribed by a physician, have you ever taken any of the following drugs? If yes, please describe usage:</b>			
( ) Morphine	( ) Barbiturates	( ) Other Narcotics	( ) Heroin
( ) Cocaine	( ) Amphetamines	( ) Marijuana	( ) Other Drugs
Primary care physician name	Address	Phone	

**Review of Physical Symptoms**

YES	NO	Check one for each symptom	YES	NO	Check one for each symptom
		Frequent or severe headaches			Low blood pressure
		Dizziness or fainting spells			Recent loss / gain weight (circle one)
		Eye problems including glaucoma			Diabetes
		Head injury			Epilepsy or seizures
		Thyroid trouble			Jaundice or liver disease
		Asthma or shortness of breath			Kidney disease
		Palpitation or pounding heart			Stroke
		Heart attack / heart trouble			MALES – Prostate trouble
		High blood pressure			FEMALES – Are you currently pregnant or planning a pregnancy in the near future?

Please list any other disease or condition you may not have listed above:

Printed name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_