Huffman Counseling Services, LLC
CLIENT INFORMATION

Date _____

Full Name _____ Age _____ Gender _____

Preferred Name _____ E-mail _____

Address _____City_____ State_____ Zip_____

Phone _____

Social Security Number (insurance users only)_____ Date of Birth _____

Married ☐ Single ☐ Widowed☐ Divorced ☐ Separated ☐

Spouse (Partner) _____ Age _____

Your Occupation _____ Employer _____

Work Address _____ Work Phone _____

Education: Elementary/ Jr. High School ☐ High School Graduate ☐ Some College ☐ College Graduate ☐ Post Graduate ☐

Children (give ages) _____

_____

Medical Conditions _____

Medications _____

Physician _____ Address_____

Phone _____

Have you ever had counseling or therapy before? Yes☐ No ☐ If yes, please give dates and with whom _____

_____

May we contact former counselor/ therapist? Yes ☐ No ☐

Are you currently under psychiatric care? Yes ☐ No ☐ If yes, Psychiatrist Name _____

Address _____ Phone _____

Are you currently taking any psychotropic medications? Yes ☐ No ☐ If yes, please list _____

_____

Who referred you? ☐ Insurance/EAP ☐ Internet Search ☐ Physician ☐ Phone Book ☐ Friend ☐ Other _____

What problems are you having that caused you seek counseling/therapy or be referred?_____

_____

_____

_____

_____

Have you ever attempted suicide or had serious suicidal thoughts? Yes ☐ No ☐ If yes, are you having suicidal thoughts now? Yes ☐ No ☐

Have you ever been hospitalized for a mental condition? Yes ☐ No ☐ If yes, when did this occur and where? _____

_____

Emergency Contact _____ Phone _____

Address _____

To the best of my knowledge, the information given above is true and correct.

Signed _____ Date _____