Betsy Deeter, LCSW
Confidential Information – Adult

Client Information

Client's Name: _____ SS#: _____ Date: _____
First Middle Last

Age: _____ Date of Birth: _____ Male/Female (circle) Education: _____

Home Address: _____
Street City State Zip

May I write you at street address? Yes No

Email address: _____ May I contact you through email? Yes No
If No, provide alternative address for correspondence: _____

Phone: home _____ work :_____ cell/pager #:_____
May I call the above numbers? Home – Yes/No Work – Yes/No Cell – Yes/No

Occupation: _____ Employer: _____ Religious Affiliation: _____

Relationship Status: _____
Spouse/Partner:

Name: _____ Relationship: _____ Education: _____
Occupation: _____ Employer: _____ DOB: _____
SS#: _____ Phone: work_____ cell _____
(only needed for insurance purposes)

Referred By: ___ Self ___ EAP ___ PCP ___ Work ___ Other (Specify) _____
Where did you find/get my name: ___ internet ___ EAP ___Insurance Co. ___ Other (specify)_____

Emergency Contact Person: _____
Name, phone number, relationship

Parents, Siblings, and Children:

Name	Relationship	Age	Grade/Occupation	Residence

Previous Mental Health Services

Types of Services	Provider	Dates of Service

For Clinician Use Only:
Diagnosis:

Patient Name: _____

Please complete the following medical information

Do you have any medical problems? Please explain: _____
_____
_____
_____

If you are under the care of a physician for a continuing health problem, please give physician's name and number and request a release form: _____

Do you take regular medication? If so please list:

Name of Medication	Dose	Frequency

Do you smoke? Yes No How much _____ How long _____
Do you drink alcohol? Yes No How Much _____ How Long ____ Is it a problem for you Yes No
Is it a problem for your family Yes No
Do you use other illicit substances? Yes No Is it a problem for you Yes No
Is it a problem for your family Yes No

Additional Information

Any Legal Involvement: Yes ☐ No☐ If yes explain: _____
_____

List your Leisure interests: _____

What do you consider your strengths? _____
_____
_____

Briefly describe the problems that brought you here: _____
_____
_____
_____

Briefly list goals of your treatment; what would you like to achieve and/or see happen by coming here for care? _____
_____
_____
_____

Is there other information you would like to share? _____
_____
_____
_____