Connie McCullar, M.S., LMFT 90573
1148 Alpine Rd. Ste 205
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(925) 285-6595
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Client Information

Name: _____ Date:_____

Address: _____ City and Zip Code:_____

Date of Birth: _____ Referred By: _____

Home Phone: _____Cell Phone: _____ Work Phone: _____

Occupation: _____ Social Security Number: _____

Emergency Contact and Phone Number: _____

Relationship to Client: _____

Physician's Name: _____ Phone:_____

Date of Last Physical Exam: _____ Please describe your overall health today. _____

Describe any health problems, major operations, illnesses or injuries: _____

_____

Marital Status: _____Name and age of spouse or partner: _____

Name and ages of children:_____

_____

Why are you seeking treatment at this time? _____

_____

What would you like to accomplish in counseling? _____

_____

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Have you received counseling in the past? _____ When and for how long? _____

_____

What was the focus of the counseling? _____

Name of therapist(s) and phone number(s): _____

_____

Have you ever been hospitalized or prescribed medicine for mental health reasons? If yes, please indicate when and where._____

_____

Have you ever attempted suicide? _____ When? _____

Describe the circumstances that lead to that event: _____

_____

Are you currently taking any prescription medications? _____

_____

Do you smoke? _____ How much and for how long? _____

On average, how much alcohol do you consume in a week? _____

Do you currently use any illegal drugs? _____ Have you in the past? _____ Please describe your use. _____

Have you had or are you currently involved in any legal problems? _____

_____

Have you ever been a victim of a crime? _____
Interests or hobbies: _____