Rachel Cahn, MA, LPC

CLIENT INFORMATION - COUPLES

CONTACT INFORMATION

Date ______________________

Name ____ Age ____________

Address ____

City ____________________________________ State ________ Zip ____________

Home Phone ____________________________ Msg ok? ______

Mobile Phone ____________________________ Msg ok? ______

Email Address ____

Emergency Contact ________________________________ Ph ____________________

Psychiatrist or MD ________________________________ Ph ____________________

Birthdate ________________ Birthtime __________am/pm Birthplace ________________

Name ____ Age ____________

Address ____

City ____________________________________State ________ Zip ____________

Home Phone ____________________________ Msg ok? ______

Mobile Phone ____________________________ Msg ok? ______

Email Address ____

Emergency Contact ________________________________ Ph ____________________

Psychiatrist or MD ________________________________ Ph ____________________

Birthdate ________________ Birthtime __________am/pm Birthplace ________________

Relationship Status ______________________ Children? __________ Ages ____________

Living Together? ____________ Referred by ______________________________________

Name: ____

Circle all that Apply

General Anxiety	Relationship Issues	Life Transition	Grief and/or Loss	Substance Abuse
Depression	Family Problems	Spiritual Issues	Loneliness	Past Sexual Abuse
Panic Attacks	School Issues	Chronic Illness	Low Self Esteem	Food/Eating Issues
Nightmares	Job Issues	Stress	Fear/Phobia	Suicidal Thoughts
Self-harm	Attention Issues	Personal Growth	Social Anxiety	Others suggested therapy

Previous Individual Therapy? _______ When and for how long? ____

Helpful? Why or why not? ____

Previous Individ. Therapist Name (s)____

Previous Couples Therapy? _______ When and for how long? ____

Helpful? Why or why not? ____

Previous Couples Therapist Name(s) ____

Briefly describe major losses or trauma ____

____

Have you ever engaged in self-harming behaviors? _______ If so, when? ___________________ Now? _________

Describe self-harm ____

Have you ever attempted suicide? _________ If so, when, how, and what happened? ________________________

____

Have you ever been hospitalized for mental health issues? __________ If so, when? _________________________

Describe ____

Drug/Alcohol use (past and present): ____

____

Significant Medical Conditions (past and present) ____

____

Prescribed Medications (past and present) ____

Do you have a spiritual path or religious affiliation? ____

Occupation: ____________________________________ Education _______________________________________

Do you have Close Friends: (Circle) None One A Few Many Acquaintances: None One A Few Many

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Name: ____

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