BRIEF THERAPY ASSOCIATES
122 West Court Street ~ Ithaca, New York 14850
(607) 275-3675 ~ www.brief–therapy.com

CLIENT INFORMATION

A. Client information

Today's Date: ___ / ___ / ___

Your Name: _____

Name of Clinician: _____

Sex: M / F Date of Birth: __/ __/ __ Email Address: _____

Address: _____

Home phone: ( ) _____ – _____ Work phone: ( ) _____ – _____

Employer: _____

Occupation: _____

B. Emergency Contact Information

Name: _____

Address: _____

Home phone: ( ) _____ – _____ Work phone: ( ) _____ – _____

C. Status: (check one) Single ___ Unmarried Couple ___ Separated ___

Divorced ___ Widowed ___ Married ___ Date of marriage ___ / ___ / ___

D. Household Composition

Name	Date of Birth	Relationship to you

E. Previous Counseling Experience:

_____

F. Financial Information

Total Household Yearly Income (gross): $_____ # of Household Members: _____

G. Health Insurance Coverage:

Name of Provider: _____

Name of Insured: _____

Your relationship to Insured: _____ ID # _____

Insured date of birth:___ / ____ /____ Insured workplace: _____

H. Medical History

Date of Most Recent Physical Exam: ___ / ___ / ___

Performed By: _____

Address of Medical Doctor: _____

Date of Most Recent Hospitalization: ___ / ___ / ___

Name of Hospital: _____

Reason For Hospitalization: _____

Are you currently taking any medications? Yes / No (If yes, please list name & purpose of each medication:)

_____

_____

Please indicate below whether you or any of your family members currently have or have in the past any of the following:

Family / Self		**Family / Self**	
____ / ____	Diabetes	____ / ____	Learning Disability
____ / ____	Ulcers	____ / ____	Other
____ / ____	Head injury/Seizures/Epilepsy	____ / ____	Cigarettes/Coffee
____ / ____	Heart Disease/Stroke	____ / ____	Hallucinogens
____ / ____	High/Low Blood Pressure	____ / ____	Alcohol
____ / ____	Cancer	____ / ____	Marijuana
____ / ____	Thyroid Gland Problems	____ / ____	Cocaine
____ / ____	Chronic Fatigue	____ / ____	Tranquilizers
____ / ____	Eating Problems	____ / ____	Other Drugs
____ / ____	Sexual Problems		
____ / ____	Blackouts, Fainting		Female Concerns
____ / ____	Sleeping Problems	____ / ____	Pregnant
____ / ____	Bowel/Bladder Problems	____ / ____	Pregnancy Loss
____ / ____	Infertility	____ / ____	Menopause
____ / ____	Hepatitis	____ / ____	Menstrual Problems
____ / ____	Asthma/Allergies	____ / ____	Gynecological Problems