Karma Counseling
Zahra Payravian, LPC

CLIENT INFORMATION FORM

DATE: _____

NAME (PRINT): _____ CELL PHONE: _____ _____

MAY WE LEAVE A VOICEMAIL? Y N (PLEASE CIRCLE ONE)

MAY WE LEAVE A MESSAGE TO RETURN CALL WITH WHOEVER ANSWERS? Y N

MAY WE TEXT YOU?Y N

AGE: _____ DATE OF BIRTH: _____ EMAIL: _____

HOME ADDRESS: _____

REFERRAL SOURCE: _____ YOUR OCCUPATION: _____

INSURANCE PROVIDER: _____ INSURANCE PHONE NUMBER: _____

POLICY/ID NUMBER: _____ GROUP NUMBER: _____

EMERGENCY CONTACT NAME & PHONE: _____

PLEASE LIST ALL INDIVIDUALS LIVING WITH YOU: (NAME, RELATIONSHIP, AGE, SEX)

_____

_____

_____

_____

OTHER CURRENTLY SIGNIFICANT INDIVIDUALS IN YOUR LIFE: (NAME, RELATIONSHIP, AGE, SEX)

_____

_____

MARRIAGES OR SIGNIFICANT/ROMANTIC RELATIONSHIPS OF THE PAST: (NAME, RELATIONSHIP, RANGE OF DATES, SEX)

_____

_____

_____

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CLIENT INFORMATION FORM (*continued*)

DO YOU EXERCISE? _____ IF YES, WHAT TYPE? _____

HOW OFTEN? _____

DO YOU DRINK ALCOHOL? _____ IF YES, HOW MUCH AND HOW OFTEN? _____

DO YOU TAKE PRESCRIPTION DRUGS? IF YES, PLEASE LIST NAME, DOSAGE& FREQUENCY.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

ARE YOU AWARE OF A HISTORY OF MEDICAL/MENTAL/SUBSTANCE ABUSE ISSUES IN YOUR FAMILY? IF YES, PLEASE DESCRIBE:

_____

_____

HAVE YOU PREVIOUSLY USED ANY TYPE OF MENTAL HEALTH SERVICES? _____ IF YES, WHEN AND FOR WHAT REASON?

_____

_____

PLEASE DESCRIBE YOUR REASONS FOR SEEKING COUNSELING NOW:

_____

_____

_____

_____

PLEASE DESCRIBE YOUR RELIGIOUS OR SPIRITUAL INFLUENCES IF ANY:

_____

_____

IS THERE ANYTHING ELSE YOU WANT ME TO KNOW ABOUT YOU?

_____

_____