COMPANY FOR HEALTHY LIVING *CLIENT ACCOUNT* _____

Client _____**Date of Birth** _____/_____/_____

Pronoun _____**Email** _____

Phone: Cell (_____) _____ **Home**__ **Work** __ **OK to? (txt__) (vm__)**

Contact if not OK with messages at text/voice/email: _____

Emergency Contact _____ **Phone (____)**_____

Partner Status: Single __ Married __ Live-in Partner __ Divorced __ Children # __ Grandchildren # __

Address _____

City _____**State** _____**Zip** _____ **Mail ok? __ Y __N**

Place of Birth _____ _____**Gender**_____ **Languages** _____**Ethnicity** _____

Insurance Company _____ **Referred by** _____

Group _____**Member #**_____

Reason for seeking services: _____

_____

If you've had therapy/counseling before, when was that _____ and did you like it: yes __ or no __

Have you ever thought about hurting ___ or killing __ yourself? Another person __? Seriously? __

If so, when _____ and what were some of the details? _____

_____

Current medical conditions:

_____

Medications you are taking at this time:

Medication	Dosage/Frequency	Date Initially Prescribed	Purpose	Effectiveness

Primary Care Physician (medical): _____Phone_____

Address_____ City _____ Zip _____

Psychiatrist/Prescriber: _____Phone_____

Address_____ City _____ Zip _____

Summarize the problems that lead you to seek help _____

_____

_____

_____

Richard Hill PhD
PSY 20326
640 Bailey Rd #225
Pittsburg, CA 94565
408.354.6783
rfhillphd@gmail.com

History of Counseling (Include dates, type of counseling, diagnosis, and name/phone of therapist):

_____

_____

Do you have any particular fears/concerns with regards to treatment at this time? _____

_____

_____

Relevant family history (include substance abuse and psychological problems for parents and siblings)

_____

_____

Have you had any legal or medical problems? _____

_____

_____

How well do you sleep at night? Awful __ Many Interruptions__ Occasional Disruption__ Soundly__

Do you keep any record of your dreams? I don't dream__ I rarely remember__ Sometimes__ Yes__

Past and current use of the following (Include amount and frequency):

	Past	Current
Coffee		
Cigarettes		
Alcohol		
Street Drugs		

Household Members				
Name	**DOB/Age**	**Sex**	**Occupation/Grade**	**Relationship within Family**
Schools				
Name	**City, State**	**Yr.Grad**	**Major/Minor**	**Did you like it?(0-5, 0=not at all)**
Recent Career				
Title	**City, State**	**When**	**Earnings Range/year**	**Do you like it? (0-5, 0=not at all)**

Please answer the following questions and describe or attach anything else that you feel is relevant**:**

1. List names, gender, and birth years of any siblings and describe your relationships with them.

_____

_____

_____

_____

2. Note if adopted or parent/s deceased, describe when, cause, and effect on you. _____

2. Describe the kind of person your primary parent is/was, your relationship, then and now.

4. Describe the kind of person your other parent(s) is (was), your relationship with them, then/now.

5. Describe any experiences that were especially upsetting in your life. _____

6. Describe your partner/spouse's personality and relationship, frustration, joy, fear with them.

7. Anything else re personal development, relationships, medical issues, or your plan for therapy:

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