Individual Client Information Sheet

Name Social Worker: _____
Medicaid: (Yes/ No) Recipient ID #:_____

Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully or ask your therapist for clarification if you do not understand an item.

Full Name: _____ Today's Date: _____

Address: _____
City State Zip

Telephone(s): _____ _____ _____
Home Work Cell

Age: _____ Birth Date: _____ Marital Status: S □ M □ D □ W □

Social Security #: _____ Referred by: _____

Your reason for seeking services:
_____
_____
_____

Family Information
List the members of your family and all others in your home:

Name(s) Age/Birth Date Relationship Occupation

Do you have children not currently living with you? Yes ___ No____ If so how many? _____

Please provide names and ages of the children: _____

Background Information

How many times have you been married? _____

Level of education completed: _____

Employed: Yes □ No □ Place of Employment _____

If unemployed give reason: _____

How long have you been employed? _____ Occupation: _____

Employer's address: _____

Name of Insurance company: _____

Medical History

When did a physician last examine you? _____

List any major health problems for which you currently receive treatment: _____

_____

List any medications you are now taking: _____

_____

Have you ever received psychiatric or psychological help or counseling of any kind before?
Yes ___ No ___

If you have, please explain:

_____

Please circle any of the following symptoms or difficulties, which pertain to you.

Nervousness	Unhappiness	Inferiority feelings	Friends
Depression	Sleep	Concentration	Anger
Fears	Stress	Education	Self-control
Shyness	Work	Career choices	Insomnia
Sexual problems	Relaxation	Health Problems	Making decisions
Suicidal thoughts	Headaches	Temper	Loneliness
Separation	Tiredness	Nightmares	Bowel troubles
Divorce	Legal matters	Marriage	Being a parent
Finances	Memory	Children	My thoughts
Drug use	Ambition	Appetite	Violence
Alcohol use	Energy	Stomach Trouble	

Do you now have or have you had any problems with drugs/alcohol? No □ Yes □ if yes indicate which drugs and last use

_____

_____

Have you been involved in violence in the home: No □ Yes □ If so how frequently? _____

Have you experience trauma? No □ Yes □ If so, describe? _____