Client History Form

Ellen Shaw-Smith, LICSW, BCN

Name:_____ Date of Birth:_____ Gender:_____

	Name	Contact Information
PCP:		
Psychiatrist:		

Married/Children/Living Arrangements:

_____

_____

Employment/School: _____

_____

Current Reason for Referral:

_____

_____

_____

Past Therapy/Therapists/Inpatient/Outpatient:

_____

_____

_____

Substance Abuse Issues Or Treatment: _____

_____

Medical Issues Affecting Health:

_____

_____

_____

Family Physical or Mental Health History Possibly Contributing to Situation:

_____

_____

_____

_____

Symptoms:

_____

_____

_____

Social Connections or Supports and Client Strengths:

_____

_____

_____

Typical Diet In A Three Day Period:

_____

_____

Prescribed or Recreational Drugs and Supplements:

_____

_____

_____