

CLIENT SELF REPORT

Client Social Security No: _____ Date: _____

Client Name: _____

Last

First

Middle Initial

Address: _____

City, State, Zip: _____ County: _____

Telephone No: Home () _____ Work/Business () _____

Date of Birth: ____/____/____ Age: ____ Sex: M or F

Who do you want to contact in case of an emergency:

Name: _____

Address: _____

City, State, Zip: _____

Telephone No: () _____ Relationship: _____

Race: _____ White Religious Preference: _____

_____ African/American Ethnic Background: _____

_____ Hispanic Martial Status: _____

_____ Native American Living Arrangements: _____

_____ Other: _____ Personal Income: _____

Household Income: _____

When was your last physical exam?

Date: _____ Results: _____

Primary Physician's Name: _____

Address: _____

Phone: () _____

Past History of Treatment

Information about client (past and present):

Type	Yes	No	# of times	Where	Outcome
Counseling/Psychiatric Treatment					
Drug/Alcohol Treatment					
Hospitalizations					
Involvement with self-help groups (e.g. AA, Al-Anon, Overeaters Anonymous, etc.)					