WAVE Professional Clinical Counselors Inc.

WAVE THERAPY
3150 Pio Pico Dr. Suite 105
CARLSBAD, CA 92008

(760) 500-3325

Client Information Form

A. Identification

Client's name: _____ Date of birth: _____ Age: _____

Your nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Calls will be discreet, but please indicate any restrictions: _____

_____

Emergency contact: _____ phone: _____

Allergies: _____

B. Your current/most recent employer/ Insurance Information

Employer: _____What do you do for work:_____

Address: _____Suite: _____

City: _____ State: _____ Zip: _____

Work phone: _____ Calls will be discreet, but please indicate any restrictions: _____

_____

Please list your Insurance: _____ ID#: _____ Group#_____

Please indicate if you are currently employed or on a leave for any reason _____

C. Chief concern

Please describe the main difficulty that has brought you to see me:

_____

_____

_____

Please briefly describe your significant relationships (spouse, children, family, friends):

_____

_____

D. Treatment

1.Have you ever received psychological counseling services before? • No • Yes If yes, please indicate:

A. Duration of services? B. From whom? C. For what? D. With what results?

_____

_____

2.Have you ever taken medications for psychiatric or emotional problems? • No • Yes If yes, please indicate:

A. Which medication? B. Purpose of medication? C. Duration it was taken? C. Prescribing psychiatrist? D. Was it effective for your symptoms?

_____

_____

3. Current/Previous mental health and medical diagnoses/illnesses? • No • Yes If yes, please indicate:

_____

4. Have you ever been hospitalized for a psychiatric emergency? • No • Yes If yes, please indicate:

_____

E. Legal history

1. Are you presently suing anyone or thinking of suing anyone? • No • Yes If yes, please explain:

_____

_____

2. Is your reason for coming to see me related to an accident or injury? • No • Yes If yes, please explain:

_____

_____

3. Are you required by a court, the police, or a probation/parole officer to have this appointment?

• No • Yes If yes, please explain:

_____

_____

4. Are there any other legal involvements I should know about?

_____

_____

Is there anything else you want your therapist to know?

_____

_____

Your signature below indicates that the above information is true and correct to the best of your knowledge.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed Name Date of Birth