

**Confidential Client Information**

Date: Referred by: Therapist:

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Client Name Age: Date of Birth:

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Home Address:

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Home Phone: Work Phone: Other:

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Insurance Company: Group#  
Phone# Policy#

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Social Security Number:

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Occupation: Education Level:

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Relationship Status: Married  Partner  Single  Separated   
Divorced

Partner/Spouse Name: Age: Occupation:

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Children's Names and Ages:

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Were you raised by: both parents  single parent  relative   
other

Mother's Name: Age: Occupation:

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Father's Name: Age: Occupation:

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Brother's and Sister's (names and ages):

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Why are you seeking counseling?

Do you or any of your family members or significant other have a history of:  
(Check all that apply)

Alcoholism       Drug Abuse (prescription and or street drugs)

Nervous Breakdown:       Prolonged illness:       Eating Disorders:

Other:

If you checked any of the boxes please explain who had the problem and provide details (dates, severity, nature of the problem etc...):

Are you taking any medications?       Yes       No      If yes, please list:

Medication name	Dosage	Reason for taking it

Do you have any significant physical problems?    Yes       No

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12340 Santa Monica Blvd. #343 Los Angeles, California 90025 (310) 289-4764

If yes, please explain:

Do you have a Primary Care Physician (PCP)?    Yes     No

If yes, please answer the following:

PCP's Name: \_\_\_\_\_

PCP's Address: \_\_\_\_\_

PCP phone number: \_\_\_\_\_

Do I have your permission to contact your PCP and tell him/her that you have entered treatment with me and coordinate services if necessary?

Yes     No

If you answered no, please tell me why: \_\_\_\_\_

Have you had any previous psychiatric care or counseling?     Yes    No

If yes, please provide the approximate dates of treatment and reasons you sought help:

Have you ever been hospitalized for a mental disorder, drug or alcohol

problem?    Yes     No     If yes, please explain:

Have you, any of your family members or significant other attempted suicide?

Yes     No     If yes, please explain:

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Are you suicidal now? Yes  No

Emergency Contact:

Phone:

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Relationship to you:

I would like to be notified by mail of upcoming events and group: Yes  No

I would like to receive complementary newsletters by mail. Yes  No

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Client Signature

Date