CONFIDENTIAL

Sarah Bridge, M.S.W., L.C.S.W
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Client Registration

Patient Information Date:_____

Name: _____ Date of Birth: _____ Age:_____
Last First MI

Address:_____
Street City State Zip

DL #: _____ Sex: M F Marital Status:_____

Home Phone: _____ Cell Phone: _____ Work: _____

Message OK? ❑Yes ❑No Message OK? ❑Yes ❑No Message OK? ❑Yes ❑No

Email:_____ Message OK? ❑Yes ❑No

Employed? ❑Yes ❑No

Occupation: _____ Employer: _____ Position: _____

Referred by: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Presenting Problem: In your own words, describe why you are here today:

_____

_____

_____

Expectations of Therapy: In your own words, describe your expectations of therapy:

_____

_____

_____

_____ _____
Client Signature Date

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS INFORMATION. IF YOU HAVE ANY QUESTIONS, PLEASE ASK. A COPY OF THIS SIGNED FORM IS AVAILABLE UPON REQUEST.

Sarah Bridge, M.S.W., L.C.S.W

Confidential History

Name: _____
Education Level: _____ Current Occupation: _____
Satisfied with your occupation? ❑ Yes ❑ No Comment: _____
Ethnicity: _____ Religion: _____
Sex: M F Age: _____ Language spoken at home? ❑ English ❑ Other: _____

Marital/Relationship Status (Check all that apply): Years Married: _____
❑ Married ❑ Living together ❑ Never married ❑ Divorced ❑ Separated
Are there current marital problems? ❑Yes ❑No
Comments: _____

Spouse/Partner Name: _____ Occupation: _____
Satisfied with job? ❑Yes ❑No

Children
Name: _____ Sex: M F Age:_____
Name: _____ Sex: M F Age:_____
Name: _____ Sex: M F Age:_____
Name: _____ Sex: M F Age:_____

Mother's Name: _____ Stepmother? ❑Yes ❑No
Occupation: _____ Highest level of education: _____
Father's Name: _____ Stepfather? ❑Yes ❑No
Occupation: _____ Highest level of education: _____

Siblings
Name: _____ Sex: M F Age:_____
Name: _____ Sex: M F Age:_____
Name: _____ Sex: M F Age:_____
Name: _____ Sex: M F Age:_____

With whom were you raised? (Check all that apply)
❑Biological parents ❑Parent and step-parent ❑Foster parents ❑Single parent
❑Adoptive parents ❑Relatives ❑Institution ❑Legal guardian ❑Other: _____

Marital Status of Parents (Check all that apply) Years Married: _____
❑ Married ❑ Living together ❑ Never married ❑ Divorced ❑ Separated
Comments: _____

Please list any major medical conditions in your family: _____
_____
_____

Your medical conditions or health issues: _____
_____
_____
Current Physician: _____ Phone #: (_____) _____ - _____
Date of most recent visit: _____ Reason: _____
Medications you take:
❑ I do not take prescription medication at this time
Medication: _____
Medication: _____
Medication: _____
Medication: _____

Please describe history of other serious illness or injuries: _____
_____
_____

Is there any family history of treatment for psychological/psychiatric conditions? ❑ Yes ❑ No
Comments: _____
Have you had previous counseling or psychotherapy? ❑Yes ❑No
With whom and when: _____
_____
Have you ever felt suicidal? ❑ Yes ❑ No Do you feel that way now? ❑ Yes ❑ No
Comments: _____

Are you involved in any legal proceedings? ❑Yes ❑No Comments: _____
_____
Have you ever been arrested? ❑ Yes ❑ No Have you ever been convicted of a crime? ❑ Yes ❑ No
Comments: _____
Do you drink alcohol? ❑ Yes ❑ No What type: _____ Frequency: _____
Do you use tobacco? ❑ Yes ❑ No What type: _____ Frequency: _____
Do you use other drugs? ❑ Yes ❑ No What type: _____ Frequency: _____

Do you have a history of alcohol or substance abuse, dependency and/or addictions? ❑Yes ❑No Comments:
_____
_____

Do you any present concerns about your current alcohol or substance use? ❑Yes ❑No Comments:
_____
_____

Do you have a history of an eating disorder (anorexia, bulimia, and/or compulsive over eating)? ❑Yes ❑No Comments:
_____
_____

Have you been a victim, past or present, of physical or sexual abuse/assault? ❑ Yes ❑ No
Comments: _____
_____

Please describe your sleep patterns (average hours of sleep per night, loss of sleep, excessive sleeping, history of sleep apnea, etc.): _____

Nutritional habits: ___poor ___fair ___good ___excellent
Exercise habits: ___poor ___fair ___good ___excellent

What is your social support system _____
_____

Did a specific event lead to this session? ❑Yes ❑No Comments: _____
_____
_____

Is there anything significant the form did not ask that you would like to add? _____
_____
_____

Client Signature _____ Date

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