

Company for Healthy Living
2880 Zanker Road, Suite 203
San Jose, CA 95134.2117

Client
Record
CHL# _____

408.354.6783
fax 831.335.2118
www.c4hl.org

Client/s _____ Date of Birth ____/____/____

Address _____

City _____ State _____ Zip _____ Mail ok? __ Y __ N

Telephone: Home(____) _____ Work(____) _____ Cell() _____

Email _____

If not OK to leave messages at phone/email shown above, show message contact: _____

Marital Status: Single __ Married __ Live-in Partner __ Divorced __ Children # __ Grandchildren # __

Emergency Contact _____ Phone _____

Client S.S. _____ - _____ - _____ Place of Birth _____

Languages _____ Ethnicity _____

Insurance Company _____ Referred by _____

Group _____ Member # _____ Authorization _____ Fee/Co-pay _____

Reason for seeking services: _____

If you've had therapy/counseling before, when was that _____ and did you like it: yes __ or no __

Have you ever thought about hurting __ or killing __ yourself? Another person __? Seriously? __

If so, when _____ and what were some of the details? _____

Current medical conditions: _____

Medications you are taking at this time:

Medication	Dosage/Frequency	Date Initially Prescribed	Effectiveness	Prescribing Physician

Primary Care Physician Name: _____

Address _____ City _____ Zip _____

Telephone (____) _____ Fax (____) _____

Psychiatrist Name: _____

Address _____ City _____ Zip _____

Telephone (____) _____ Fax (____) _____

History of Counseling (Include dates, type of counseling, diagnosis, and name/phone of therapist):

Do you have any particular fears/concerns with regards to treatment at this time? _____

Relevant family history (include substance abuse and psychological problems for parents and siblings)

How well do you sleep at night? Awful__ Many Interruptions__ Occasional Disruption__ Soundly__

Do you keep any record of your dreams? I don't dream__ I rarely remember__ Sometimes__ Yes__

Past and current use of the following (Include amount and frequency):

	<u>Past</u>	<u>Current</u>
Coffee	_____	_____
Cigarettes	_____	_____
Alcohol	_____	_____
Illegal/ Drugs (Street/Social: which ones)	_____	_____

<i>Household Members</i>				
Name	DOB/Age	Sex	Occupation/Grade	Relationship within Family
<i>Schools</i>				
Name	City, State	Yr. Grad	Major/Minor	Did you like it?(0-5, 0=not at all)
<i>Recent Career</i>				
Title	City, State	When	Earnings Range/year	Do you like it?(0-5, 0=not at all)

Please answer the following questions (if more room is required feel free to use back side of paper):

1. List the names, sex, and birth years of any siblings and describe your relationships with them.

2. Describe the kind of person your father is (was) and your relationship with him while growing up and now. _____

3. Describe the kind of person your mother is (was) and your relationship with her while growing up and now. _____

4. If parent/s are deceased, describe when, cause of death, and effect on you. _____

5. Describe any experiences that were especially upsetting in your life. _____

6. Describe your partner/spouse's personality and describe your relationship with them. _____

7. Please feel free to include any other information that you believe is relevant to your treatment.
