

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](http://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: \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Client S.S. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Referred by \_\_\_\_\_

Languages \_\_\_\_\_ Ethnicity \_\_\_\_\_

Insurance Company \_\_\_\_\_ Place of Birth \_\_\_\_\_

Group \_\_\_\_\_ 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 \_\_

At any time in your life, have you thought about hurting \_\_ or killing \_\_ yourself? 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 |
|------------|------------------|---------------------------|---------------|-----------------------|
|            |                  |                           |               |                       |
|            |                  |                           |               |                       |
|            |                  |                           |               |                       |
|            |                  |                           |               |                       |

Allergies/adverse reactions to medication/s: \_\_\_\_\_

**Primary Care Physician Name:** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

**Date of Request** \_\_\_\_\_ **Name of Caller** \_\_\_\_\_ **Intake** \_\_\_\_\_ **Clinician** \_\_\_\_\_ **Initial Appt** \_\_\_\_\_

**Source of Referral:** \_\_ (CCSJ) \_\_ (Psych Today) \_\_ (web site) \_\_ (County/which?) \_\_ (school/which?)

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

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

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

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**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<br>(Street/Social:<br>which ones) | _____       | _____          |

***Household Members***

| Name | DOB/Age | Sex | Occupation/Grade | Relationship within Family |
|------|---------|-----|------------------|----------------------------|
|      |         |     |                  |                            |
|      |         |     |                  |                            |
|      |         |     |                  |                            |
|      |         |     |                  |                            |

***Schools***

| Name | City, State | Yr.Grad | Major/Minor | Did you like it?(0-5, 0=not at all) |
|------|-------------|---------|-------------|-------------------------------------|
|      |             |         |             |                                     |
|      |             |         |             |                                     |
|      |             |         |             |                                     |

***Recent Career***

| 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.**

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

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

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

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

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

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

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