

Robert Kallus, M.S., L.M.F.T.

CLIENT DATA

Date: _____

Client Name (Please Print) _____

Address _____ City _____ State _____ Zip _____

Phone Numbers: Home () _____ Mobile: () _____ Work: () _____

e-mail addresses: _____

Date of Birth _____ Social Security # _ _ - - - - -

Others in your household:

<u>NAME</u>	<u>AGE</u>	<u>RELATIONSHIP</u>

Children living out of the home _____

Place of employment _____ Title _____

Emergency contact person: _____

Phone: Home () _____ Mobile: () _____ Work: () _____

If you are being treated for any major health problems, please explain: _____

Do you have physical pain or distress? (Headaches, migraines, digestive pains, joint OR back pain, etc.) Y N

If yes, please explain _____

Are you experiencing pain now? Y N please explain _____

What medications do you currently take? _____

Name and towns of your physician _____

Have you or has anyone expressed the belief that you have a substance abuse, overuse, or addiction problem? Y N

Please explain _____

Have you had counseling or therapy before? Y N If yes, please describe _____

Have you ever attended a counseling, therapy or self-help group? Y N If yes, please describe _____

