JODIE GEORGE, MA, LMFT

## *CLIENT PROFILE*

**This questionnaire will assist me in planning your treatment. Please fill it out as completely as possible. All information will be kept strictly confidential except where disclosure is required by law.**

Client Name: _____ M ❑ F ❑

Address: _____

City: _____ ST: ___ Zip: _____

Phone (home) _____ Phone (work) _____

Social Security #:_____ Date of Birth _____

Referred by _____

Married ❑ Single ❑ Divorced ❑ Widowed ❑ How long _____

Spouse's Name _____ Spouse's Occupation _____

Children (Ages and Sex) _____

_____

_____

List previous counseling or treatment, including type and length

_____

_____

_____

Current medical problems _____

Medical treatment and/or medications _____

_____

Personal physician's name and telephone number _____

_____

Do you currently drink alcohol or use non-prescribed drugs? _____

List types, amount, and length of usage _____

_____

List others in your present family or family of origin who use drugs or alcohol: _____

_____

Who were the members of your family of origin? _____

_____

Who did you feel closest to growing up? Closest to today? _____

_____

Religion or spiritual preference _____

Have you had serious thoughts about suicide; if so, how recently?

_____

What issues bring you to treatment _____

_____

What results would you like to see from your treatment? _____

_____

Other information significant to your treatment _____

_____

Name, address, and telephone number of person to contact in case of emergency _____

_____