



**Client Information**

Date: \_\_\_\_\_

Name (Last, First, Middle Initial): \_\_\_\_\_

Address: \_\_\_\_\_

County: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Employer: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Gender:  Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Are you currently:  Married  Single  Divorced  Separated

If divorced or separated, when? \_\_\_\_\_

Ethnicity: (statistical purposes only)

- 1- Caucasian  3 - Hispanic  5 - Asian  
 2 - African American  4 - Native American  6 - Other

Payor Source:  Idaho Medicaid  Dept Health & Welfare  Private Pay / Insurance

If referred by the Dept of Health & Welfare, name of assigned case manager: \_\_\_\_\_

If private pay, name of Insurance Company : \_\_\_\_\_

Name of regular physician: \_\_\_\_\_

Special Needs:  Blind/Visually Impaired  Deaf/Hearing Impaired  Developmentally Delayed  
 Physically Handicapped  Other \_\_\_\_\_

Annual Household Income Level: (statistical purposes only)

- < \$8,000  \$12,001 - \$17,000  \$24,001 - \$30,000  
 \$8,001 - \$12,000  \$17,001 - \$24,000  > \$30,001

Are finances currently a stressor for you?  Yes  No

Explain: \_\_\_\_\_

**Health History/Medical Concerns**

Please describe any medical conditions or concerns: \_\_\_\_\_

\_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_

**Major Illnesses / Surgeries**

Have you had any major illnesses or surgeries?  Yes  No

If yes, please list below:

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### Allergies

Do you have any food or medication allergies?  Yes  No

If yes, please list below:

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### Daily Habits

Hours sleep per night: \_\_\_\_\_

Have you had any sleep problems?  Yes  No

If yes, please explain:

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Have you had any changes in weight recently?  Yes  No

If yes, please explain:

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### Past Abuse Information

Type of Abuse: (check all that apply)

<input type="checkbox"/> Child Victim/Physical Abuse	<input type="checkbox"/> Child Victim/Sexual Abuse
<input type="checkbox"/> Adult Victim/Sexual Assault	<input type="checkbox"/> Child Victim of Neglect
<input type="checkbox"/> Adult Victim of Domestic Violence	
<input type="checkbox"/> Other _____	

Your age at time of primary abuse? \_\_\_\_\_

Offender's Relationship to you? \_\_\_\_\_ Age of Offender at time of abuse? \_\_\_\_\_

Was your abuse reported?  Yes  No

Was the offender held accountable/charged?  Yes  No

Where you protected and supported by your family?  Yes  No

Please explain: \_\_\_\_\_

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Are you currently experiencing any challenges or difficulties from your past abuse?  Yes  No

If yes, please explain: \_\_\_\_\_

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Are you currently being seen by a counselor or therapist?  Yes  No

If yes, name of counselor or agency: \_\_\_\_\_

### Family History

Please mark if any family members (parent, sibling, grandparent, etc.) have a history of the following conditions:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol  | <input type="checkbox"/> Attention Deficit Disorder |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Anxiety Disorder           |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Depression        | <input type="checkbox"/> Past childhood abuse       |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Suicide           | <input type="checkbox"/> Domestic Violence          |
| <input type="checkbox"/> Genetic disorder    | <input type="checkbox"/> Bipolar disorder  | <input type="checkbox"/> Other _____                |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Alcoholism        | _____   |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Drug Abuse        | _____   |

### Social History

How would you describe yourself? \_\_\_\_\_

How do you comfort yourself? \_\_\_\_\_

How do you express anger/frustration? \_\_\_\_\_

How would you describe your current relationships? \_\_\_\_\_

What are your current fears? \_\_\_\_\_

Have you experienced any recent changes or losses?  Yes  No

If yes, please explain: \_\_\_\_\_

Additional comments or concerns: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_