HelpNet

HNClientInfo083115EJ

## CLIENT INFORMATION FORM

Name: SSN: Date:

Address: City/State: Zip: County:

Preferred Telephone Number: Ok to leave message? ☐Y ☐N Email:

Secondary Telephone Number: Ok to leave message? ☐Y ☐N

DOB: Age: Race/Ethnicity: Gender: ☐Male ☐Female ☐Other

Marital Status: ☐Single ☐Married ☐Live-In Companion ☐Separated ☐Divorced ☐Widowed

**What brings you here today, and when did this problem begin?**

**Who referred you to HelpNet?**

**Emergency Contact Name:** **Phone:** **Relationship to you:**

## EMPLOYER & STATUS

Status: ☐Employed ☐Unemployed ☐Retired ☐Full-Time ☐Part-Time ☐Salaried ☐Hourly

Employer: Position:

## INSURANCE INFORMATION

Insurance: Policy #: Group #:

Policy Holder’s Name: Employer: Relationship to you:

DOB: SSN:

## HEALTH & MEDICAL

Primary Care Physician: Phone:

Please list medical conditions:

Have you had mental health treatment before and/or substance abuse treatment before? If so, please describe:

Please list prescribed & over-the-counter medications:

| Medication | Dosage | How Often | What is it for? |
|---|---|---|---|
| | | | |
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**If bringing a child in, please list the contact information of custodial parent(s):**

| Name: | Phone: | Address: |
|---|---|---|
| Name: | Phone: | Address: |

**Who lives in your home?**

| Name | Age | Relationship to you |
|---|---|---|
| | | |
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| | | |
| | | |
| | | |

**Please list substances you've used in your lifetime:**

Tobacco Caffeine Alcohol Marijuana Cocaine (powder) Crack Cocaine Heroin Hallucinogens Opiates

Pain Medications Sedatives Synthetic Drugs Methamphetamines Prescription Drugs (misuse) Inhalants

| **Substance Type** | | | **Current Use (last 6 months)** | | **Past Use** | |
|---|---|---|---|---|---|---|
| | Yes | No | Frequency | Amount | Frequency | Amount |
| | | | | | | |
| | | | | | | |
| | | | | | | |
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| | | | | | | |
| | | | | | | |
| Other____________ | | | | | | |

| **I am experiencing…** | **Never** | **Sometimes** | **Often** | **Always** | **Check if present in family history** |
|---|---|---|---|---|---|
| Sadness/depression | | | | | |
| Wide mood swings | | | | | |
| Poor concentration/Distractibility/Memory/Confusion | | | | | |
| Anxiety/Fear/Panic | | | | | |
| Sleep problems | | | | | |
| Weight gain or loss, or appetite problems | | | | | |
| Anger/Irritability | | | | | |
| Lack of motivation/energy | | | | | |
| Alcohol/drug use/Addiction issues | | | | | |
| Physical/Sexual/Emotional Trauma | | | | | |
| Recurring, disturbing memories | | | | | |
| Self-harm behaviors (i.e. cutting, burning yourself) | | | | | |
| Hallucinations or delusions | | | | | |

| | | | |
|---|---|---|---|
| Have you ever had serious thoughts to do harm to… | ☐Yourself | ☐Someone Else | ☐Never Experienced |
| Have you ever attempted… | ☐Suicide | ☐Homicide | ☐Never Attempted |
| Are you thinking about causing harm right now to… | ☐Yourself | ☐Someone Else | ☐No |

**Client Signature/Date** **Clinician Signature/Date**