TAMPA COUNSELING AND WELLNESS

CLIENT INFORMATION FORM

Name: _____ Todays Date: _____/_____/_____

Birth Date: _____/_____/_____ Age: _____ Social Security #: _____-____-_____

Race: _____ Ethnicity: _____

Address:

_____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____ Voice Message OK: □Yes □No Text Message OK: □Yes □No

Email:

_____

Would you like to receive appointment reminders via email? □Yes □No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

EMERGENCY CONTACT:

Name: _____

Relationship:_____

Phone Number: (_____) _____-_____

Have you received mental health services in the past? □No □Yes

If yes, please provide:

Name of provider or facility: _____

Location (city/state): _____

Length of treatment:

_____

Reason for treatment: _____

MEDICAL/HEALTH HISTORY

Name of primary care physician/doctor: _____

Address: _____ Phone: _____

Please any health problems you are currently experiencing or have been diagnosed with in the past:

_____

_____

_____

Please list medication you are currently taking:

Medication	Dosage	Condition/Reason

Please describe any past or current **alcohol**/**drug** use:

_____

_____

Please describe any past/current **legal issues**:

_____

_____

EDUCATION

Highest grade completed: _____ Degree type:_____

Major(s): _____

MILITARY EXPERIENCE

Branch of Service: _____ Job/MOS:_____

Years in Service: From _____ To: _____

Type of Discharge (*honorable, dishonorable, medical, other*): _____

Last Rank Held: _____ Number of Deployments:_____

Combat Experience:

_____

_____

_____

CAREER/OCCUPATION

Current Occupation: _____ Title:_____

Employer: _____ Years: _____

MARITAL HISTORY

Current marital status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed Number of marriages: _____

Number of years: Married ____ Separated ____ Divorced ____ Widowed _____

Number of children: _____

Who resides in your home with you?
_____

FAMILY BACKGROUND

Where were you born: _____ Number of siblings: _____

By whom were you raised (*parents, grandparents, other*): _____

Briefly describe your childhood experience and role in the family:

_____
_____

Are you aware of any psychiatric/psychological issues in your family? Describe.

_____
_____

_____
Printed Name

_____
Client Signature

OR

_____
Printed Name

_____
Legal Guardian Signature

_____
Date