

Client Admission Summary
Angela Ray Smith, LPC

Client Name: _____ Referred By: _____

DOB: _____ Age: _____ Mar.Stat: _____ SSN: _____

Address: Street: _____
City: _____

Phone: (H): _____ (C): _____ (W): _____

Email: _____

Emergency Contact: _____

Reasons for seeking, goals or expectations for Counseling/Therapy:

Family: Names & ages of persons living in home:

Educational Background: Schools attended, programs completed, dates of completion:

Current Employment: Your job, regular duties, job satisfaction:

Family History/Special Circumstances: parental substance abuse; physical, emotional, or sexual abuse; mental illness, incarceration, legal issues, court involvement, court orders:

Any suicidal thoughts, attempts, or plans:

If you have suicidal thoughts, will you contract for a plan of safety? YES _____ NO _____

Date safety plan contracted: _____

In an average day or week, describe nutritional intake inc. sugar, caffeine, water, alcohol.
Recent changes?

In an average day or week, describe type and level of exercise. Recent changes?

Medical History: Hospitalizations, medications, injuries – especially head injuries, chronic conditions:

Previous Counseling or Therapy:

Current medications, when & by whom prescribed; effects:

Current Physicians:

PCP: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Other: _____ Phone: _____

Consultation permitted: YES _____ NO _____

Release form signed: YES _____ NO _____