Dr. Anita Hauenstein

Date _____ File _____

Confidential Client Information

(Please print clearly.)
Full Name: _____

Date of birth: _____ Age: _____

Full Address: _____

Preferred phone:_____ Alternate: _____

Permission to leave voice mail? Y/N Text? Y/N Email:_____

Occupation: _____ Length of Employment: _____

Referral Source: _____

Education

Grade completed: _____ High School Diploma? Yes/No

Business/Technical School: Area of study _____ Certificate? Y/N

College (circle): 1 2 3 4 Degree _____

Graduate School: 1 2 3 4 Degree _____ Area of Study _____

Emergency Contact: Name _____

Number: _____ Relation to you: _____

Relationship Status: *(Please circle)*

Single Married Committed Partnership

Separated Divorced/Divorcing Widowed

Medical Information

Do you have any current medical problems? If so, please explain:

_____

_____

Do you take regular medications? _____ *(If so, please list on back if needed.)*

_____

Do you smoke? Yes/No How much? _____ How long? _____

Have you ever received help for drug or alcohol issues? Yes/No

Has a family member received help for drug or alcohol issues? Yes/No

If yes, relation to you? _____

Previous Therapeutic Services

Have you ever received counseling or psychotherapy? Yes/No

Was it helpful? Yes/No If yes, how? If not, why not? _____

_____

Have you received assistance from other healing modalities? Yes/No

If so, what has been helpful? _____

_____

Current Situation

Please describe your reasons for seeking assistance at this time:

_____

_____

What are you hoping for (as a result of our working together)?

_____

_____

Current support system: _____

_____

Current stressors: _____

Any additional information you'd like to share: _____

_____

Thank you.