Debra R. Thompson, MA, LPCC, LPAT, ATR-BC 505-474-9358

Client Information Form

Date_____ SS#_____
Name_____ Phone (Home) _____
Address_____ (Work) _____
City_____State_____Zip_____ (Cell) _____
Date of Birth _____ Place of Birth_____ Email _____
Occupation_____
Employer_____ Education HS ____ BA ____ MA ____ PhD ____
Insurance_____ Group#_____ ID# _____
Name of Insured_____ Referred by_____

Family/ Relationship Information:
Spouse or Partner_____ Phone_____
Relationship Status_____Who lives in your household? _____
Children names & ages_____
Emergency Contact_____ Phone_____

Health/Medical Information:
Medical Treatment History (including addictions) _____
_____

Current Doctor and last visit_____ Phone_____
Consent to inform PCP of MH Treatment Yes, signed _____ No, refused_____
Medical Problems _____Current Meds_____
Allergies_____ Reactions_____

Mental Health Treatment History (names of providers, types and dates of treatment)
_____
_____

Suicide Risks_____ Previous Attempts _____Hospitalizations_____
Homicidal Risks_____ Legal Issues_____
Spiritual or Cultural Issues which may affect treatment _____
Community Resources Accessed_____

Reason for Seeking Counseling now _____
_____

What is the most important issue you would like to address? _____
_____

How will you know when you have met your desired goals for this issue? _____
_____