CRAINE COUNSELING AND CONSULTING GROUP
ELLEN M. CRAINE, JD, LMSW-Clinical and Macro, ACSW, INHC
Therapist, Social work Ethics Consultant,
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CLIENT INFORMATION – ADULT

(PLEASE PRINT)

Name _____Date _____
First Middle Last

Age _____ Date of Birth _____Sex: Male ☐ Female ☐

Home Address _____
Street City State Zip

Cell phone _____ Home phone _____Work Phone _____

Please circle the phone number you would prefer be used to contact you.
Is it ok to leave a detailed and confidential message at that number? Yes ☐ No ☐

e-mail address _____

Birthplace _____ Place(s) where raised _____

Occupation _____ Employer _____

Highest level of education achieved _____

Name and Dates of Educational Institutions attended (post-high school) _____

Any religious affiliation?_____ If so, are active, sporadic, or lapsed?_____

Marital Status _____ If married, date of present marriage _____

If in a committed relationship but not married, how long have you been together? _____

If applicable, dates of previous marriage(s)/committed relationships _____

Children (ages; please note if children live with you are if they are from a current or previous relationship/marriage)

Parents (please list ages and occupations; if deceased, please note year and cause of death)

Highest Level of Education Achieved by parents:_____

Siblings (Please list ages and occupations and if they are half or full siblings. Please also list highest level of education achieved by each. If deceased, please note year/age and cause of death)

If military, indicate branch of service, MOS, active duty/reserve/retired/dependent and dates:

If you, or anyone in your family, is in the military, please give deployment history including date(s) and location(s)

CURRENT MEDICATIONS

Name of Medication	Dose	Frequency

Are you taking any vitamins/nutritional supplements/homeopathic remedies? If so, what, dose and frequency should be listed:

Physician's Name: _____

Are there any medical conditions that I should be aware of?_____

If you are currently under the care of a psychiatrist, please give psychiatrist's name and phone number:

Emergency Contact Person _____Relationship_____

Phone # of Emergency Contact Person _____

Referral Source (who referred you or how did you hear about my services)? _____

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Current or previous counseling, treatment, and/or support group experience:_____

Any family or personal history of mental illness, alcoholism, substance abuse, suicidal thoughts, suicidal attempts or completed suicides I should know about? _____

Are you having any suicidal thoughts right now? _____

Reason for seeking help now:

Please sign below to verify that the information on this completed Adult Client Information Form is your information provided by you:

_____ _____

Signature Date