Spring Hill Counseling

Date _____

CLIENT HISTORY

Please answer the following questions completely. Your answers will help us design a treatment plan which is most appropriate for you.

Name _____ Date of Birth _____

Please explain your goal(s) for seeking treatment at this time: _____

_____

_____

_____

How severe is the problem? ☐ Mild ☐ Moderate ☐ Severe ☐ Disabling

How long has this problem been troubling you? _____

Please list any additional concerns:

_____

_____

_____

Please list any previous counseling, hospitalization, or substance abuse treatment:

Date	Reason	Provider	Inpatient/Outpatient

Please list any medications you are currently using (including over-the-counter drugs, vitamins, and herbals):

Medication	Dose	Date of initial Rx	Prescribing MD

Please list any allergies you have: _____

The information I have provided is complete and accurate to the best of my knowledge.

_____ _____

Client signature *Date*