Elizabeth Orchard, LICSW
11050 5th Avenue NE Suite 205
Seattle, WA 98125
(206) 854-1828

Client Information Form

A. Identification

Client name: ______________________ Date of birth: ______________ Age: _____

Address: ______________________ City: ______________ State: _____ Zip: __________

Home/evening phone: ______________________ e-mail: ______________________

Cell Phone: ______________________ Is it OK to leave a message? ______________

B. Emergency information

If some kind of emergency arises and I cannot reach you, or I need to reach someone close to you, whom should I call?

Name: ______________________ Phone: ______________ Relationship: ______________

Address: ____

C. Chief concern

Please describe the main difficulty that has brought you to see me: ______________________

____

____

D. Your medical care:

1. From whom or where do you get your medical care?

   Clinic/doctor's name: ______________________ Phone: ______________

   Address: ____

2. Please list *all* diseases, illnesses, important accidents, and injuries, surgeries, hospitalizations, periods of loss of Consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/Diagnosis	Treatment Received	Treated By	Result

3. Do you have any allergies? _______ If yes, please list allergen and reaction

   ____

4. List *all* medications, drugs, or other substances you take or have taken in the last year--prescribed, over-the-counter, vitamins, herbs, and others. ______________________

   ____

5. What kinds of physical exercise to you get? ______________________

   ____

6. Do you have any problems getting enough sleep? ______________________
7. Have you received the COVID19 Vaccination? _____ Date Recieved (1st Dose) __________ (2nd Dose) ______________

Continued on Back

E. Treatment

1. Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

❑ No ❑ Yes If yes, please indicate:

When? From whom? For what? With what results?

2. Have you ever taken medications for psychiatric or emotional problems? ❑ No ❑ Yes If yes, please indicate:

When? From whom? Which medications? For what? With what results?

F. Chemical use

1. How many cups of caffeinated beverages (coffee, tea, soda, energy drinks) do you drink each day? _______________
2. How much tobacco do you smoke or chew each week? ____
3. How much beer, wine, or hard liquor do you consume each week, on the average? ________________________________
4. Have you ever used illegal drugs (marijuana, cocaine, heroin, methadone, etc)? ❑ No ❑ Yes

   If yes, which and when? ____

G. Your education and training

What it the highest grade you completed? _______________________Where:________________________When?__________

H. Employment

Current Employer: ____Job Title:____________________________

I. Legal history

1. Do you have any outstanding legal concerns (court cases, traffic tickets, criminal cases, incarcerations, probation, etc)? If yes, please explain ____

   ____

J. Other

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper: ____________________________________

____

____

____

____

____

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.