

Outside the Box Counseling LLC
Client Demographic Information

Basic Information

Patient Name: _____ Date of Birth: _____

Gender: _____ Pronouns: _____

Race: _____ Ethnicity: _____

Have you been in the military? Y/N If yes: Active or Inactive Branch: _____

Marital Status: _____

Home Address: _____

Home Phone Number: _____ May we leave a message? Yes No

Work Phone Number: _____ May we leave a message? Yes No

Mobile Phone Number: _____ May we leave a message? Yes No

May we send a text message? Yes No

Email Address: _____ May we email you? Yes No

If the above patient is a minor complete the following:

Name of Guardian: _____ Relationship: _____

Address of Guardian: _____

Guardian's Home Phone: _____ May we leave a message? Yes No

Guardian's Work Phone: _____ May we leave a message? Yes No

Guardian's Mobile Phone: _____ May we leave a message? Yes No

Emergency Contact Information

In case of an emergency, who should we contact?

Name: _____

Relationship: _____

Address: _____

Phone Number: _____

Referral Source

Who referred you to our office, or how did you learn about our practice?

(Please turn over and complete Medical History and Signature)

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Medical History

List any current or important past medications

Medication & Dose: _____

History of health concerns, serious illnesses, conditions, or major operations requiring hospitalization during your life time: _____

Have you experienced any head injuries? Yes No
If yes, did you lose consciousness? Yes No
Have you experienced convulsions or seizures?
 Yes No If yes, did you also have a fever? Yes No

List any allergies you have: _____

How would you rate your current physical health?

Excellent Very Good Good Fair Poor Very Poor

Do you have a primary care physician? Yes No

If yes, complete the following:

Name: _____

Address: _____

Phone Number: _____

What was the date of your last physical or routine health "check up?": _____

Is there any additional information that you believe it is important for your counselor to know in order to provide you with the best care possible? _____

I attest that to the best of my knowledge the information provided above is accurate.

Signature of Client or Guardian

Date