Stephan P. Michener, LCSWR, SAP
Individual, Couple and Family Counseling
(585) 383-4478

500 Perinton Hills
Fairport, NY 14450

Client Information

Client Name_____ **DOB**_____

Street Address_____ **Age** _____

Town_____ **ZIP**_____ **Insurance or SS#**_____

Home Phone _____ **Work Phone** _____

Cell Phone _____**Email** _____

Where do you prefer I contact you if I need to? _____

Insurance _____ **Subscriber**_____

Insurance or SS# of subscriber_____

Subscriber DOB _____

Employer or school you attend_____

Level of Education _____

Please circle **Never married** **Married** **Separated** **Divorced**

Emergency contact (name and phone number) _____

Primary Care Physician _____

Please list family members and others who live with you

Name	relationship	Age

Previous counseling? Yes No Name of counselor or program_____

Over please

Please answer the following questions as fully as possible

1. Place a check mark next to each item that you experience.

___ sleep difficulty	___ loss of appetite	___ increased appetite
___ crying spells	___ sad feelings	___ irritable mood
___ depressed mood	___ trouble concentrating	___ desire to be alone
___ anxious feelings	___ angry outbursts	___ loss of interest in activities
___ decreased sexual desire	___ thoughts of death	___ suicidal thoughts
___ intense panic	___ extreme apathy	___ trouble waking up
___ low energy	___ low self esteem	___ hopelessness
___ worthlessness	___ Guilt	___ isolation
___ Loss	___ Stress	___ Headaches
___ Loneliness	___ Heart pounding/racing	___ Chest Pain
___ Trembling/shaking	___ Chills/ Hot flashes	___ Sweating
___ Tingling/numbness	___ Fear of dying	___ Nausea
___ Fear of going crazy	___ Phobias/fears	___ Nightmares
___ Obsessions	___ Compulsive behavior	___ racing thoughts
___ Intrusive thoughts	___ Relationship problems	___ Sexual problems
___ Physical abuse	___ Sexual abuse	___ Spousal abuse
___ Blackouts	___ Excessive drinking	___ drug abuse
___ Prescription abuse	___ Over spending/gambling	

2. Allergies _____

3. When was your last visit to you doctor?_____

4. Please list any medications you are taking _____

_____

5. Please list any medical conditions you are experiencing _____

_____

6. Use of Alcohol/Drugs _____

7. Use of Cigarettes/Caffeine _____

8. In your family is there a history of; alcoholism/substance abuse _____, mental illness _____ ,

Suicide/attempts _____

9. What is happening in your life which resulted in this appointment? _____

_____

10. What would you like to see accomplished in therapy? _____

_____