Rachel F. Beck, LCSW-C

P.O. Box 16355 • 732 Deepdene Road Baltimore, Maryland 21210
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Client Information

Full Name:_____

First Middle Last

Birth date: _____ Age: _____

Referred by _____

Street Address:

_____

_____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email _____

Emergency Contact _____

Any Disability: __No __ Yes Describe: _____

Health:

Primary Care Physician's Name: _____

Phone Number:_____ Date of your last visit: _____

Reason for that last visit: _____

_____

Medications you are taking: _____

Briefly describe your medical health, problems, and any hospitalizations _____

_____

_____

Current or previous psychiatric care, alcohol, or drug treatment? If yes, name of doctor and brief explanation_____

Any past counseling? _____ With whom and when?_____

_____

Outcomes?_____

_____

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Household Status:

Marital Status: ___ Married ___ Single ___ Separated ___ Divorced ___ Widowed

Who do you currently live with?

_____

Do you have any children? ___ Yes ___ No Living with you? ___ Yes ___ No

Names/Ages of children:_____

Background Information:

Education: _____

Source of Income: _____

Employment:_____

_____

Why are you seeking counseling?

_____

_____

_____

What are your goals of counseling?

_____

_____

_____

_____

_____

_____ _____

Signature Date