Client Information Form

Today's Date: _____

Client's Name: _____

Address: _____

_____

Client's Date of Birth: _____

Client's Phone Number: (best one to reach you at and identify location; home cell, work, etc. If client is minor, please include which parent's phone number is listed): _____

Okay with receiving text message appointment reminders? ____Yes ____No

Email address: _____

Okay with receiving email message appointment reminders? _____Yes ____No

Emergency Contacts (at least one is needed)

_____ _____
First and Last Name Phone

_____
Relationship

_____ _____
First and Last Name Phone

_____
Relationship

CLIENT'S FAMILY

Name:	Relationship to you	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What problems have caused you to seek therapy?

_____

_____

_____

_____

_____

_____

What are the goals you'd like to accomplish in therapy?

_____

_____

_____

_____

_____

Referred by:

_____

CAGEAID

Have your ever:

C felt you ought to **cut** down on your drinking or drug use?

A had people **annoy** you by criticizing your drinking or drug use?

G felt bad or **guilty** about your drinking or drug use?

E had a drink or used drugs as an **eye opener** first thing in the Morning to steady your nerves, or get rid of a hangover or to get the day started?

Scoring: Each question is scored 1 point.
A score of 1 raises suspicion of alcohol or drug abuse.
A score of 2 or more indicates likelihood of abuse, i.e. alcohol or drug use disorder.