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:

_____

Kiddie-CAGE

1. Have you used more than one **chemical** at the same time in order to get high?
2. Do you **avoid** family activities so you can use?
3. Do you have a **group** of friends who use?
4. Do you use to improve your **emotions** such as when you feel sad or depressed?

Scoring: Each question is scored 1 point.
A score of 2 or more indicates the likelihood of a substance use disorder.