Debra Kaplan, LLC
MA, MBA, LPC, LISAC, CMAT, CSAT-S
6151 E. Grant Road
Tucson, Arizona 85712
520.203.1943

Today's Date: ________________________ **Close Date**: _________________________

CLIENT INFORMATION:

1) Name: ____________________________ Date of Birth: _______________________

2) Gender: Male________ Female_______ Transgender _______ Transsexual _______

3) Status: Married_______ Divorced ________ Separated _________ Single ________

4) Phone: (Cell or Wk) ________________ Can I leave messages? ____Yes ____No

Phone: (Home) ____________________ Can I leave messages? ____Yes ____No

5) Email: ____

6) Address: __________________________ City: ______________________________

7) State: _____________________________ Zip: ______________________________

8) Are there others living at home with you? (Please indicate relationship, name and age)

____

____

Guardian Signature: _______________________ Date: ______________

Client Signature: __________________________ **Date**: ______________

Therapist Signature: ________________________ **Date**: ______________

Client Name: ___________________________

9) Are you employed: Yes ________No __________

10) Education completed: High School ____________ GED ___________ College _____________

Post-Graduate _________

11) Please indicate which substances *you are currently using AND have used in the past.*

	Alcohol	Amphetamines	Opioids	Narcotics	Cannabis	Caffeine	Tobacco
Amount							
Times per/wk							
Route							
Date of last use							
Date of first use							

12) Please indicate *family-of-origin (*family in which you were raised*)* history of substance abuse:

____

____

____

13) Please indicate history of physical/sexual/emotional abuse:

____

____

____

Guardian Signature: _______________________ **Date**: _______________

Client Signature: ___________________________ **Date**: _______________

Therapist Signature: _________________________ **Date**: _______________

Client Name ______________________________

14) Are there any cultural/spiritual issues that might hinder or support your therapeutic process?

____

____

15) Primary Care Physician: ______________________ **Phone:** ____________________________

____

16) List any known current medical problems:

____

____

17) Are you currently being treated by a psychiatrist for medication? Yes ______No _________

18) In the event of an emergency, I may need to contact your prescribing psychiatrist. Please indicate the following information: ** Signed Release of Information form needs to be on file

Psychiatrist Name: _________________________ **Phone:** ______________________

19) Have you ever been hospitalized for psychiatric treatment? Yes ________ No _________ (If yes, please list reasons and dates of hospitalization).

____ _

____

20) Please list medication(s) and dosage(s) that you are currently taking:

____

____

Guardian Signature: _______________________ **Date**: ______________

Client Signature: _________________________ **Date**: ______________

Therapist Signature: _______________________ **Date**: ______________

Client Name ______________________________

21) Have you ever attempted suicide? Yes ________ No ___________

If yes, please indicate dates and detail of event(s): _____________________________________

____

____

22) Have you worked with a therapist before? Yes ______ No _________ Dates: ______________

May I contact this person(s)? Yes ________ No ___________
**** Signed Release of Information form needs to be on file**

24) How were you referred to this office? _______________________________________

25) Who may I thank for referring you? _______________________________________

23) FINANCIALLY RESPONSIBLE PARTY'S INFORMATION:

Name: ____

Relationship to you: ____

Phone: (if different from above) ____

Address: (if different from above) ____

City ____________________ State _______________ Zip _______________

Guardian Signature: _______________________ Date: ______________

Client Signature: _________________________ Date: ______________

Therapist Signature: _______________________ Date: ______________