Addiction & Mental Health Counseling of San Diego
11417 West Bernardo Ct., Suite K
San Diego, CA 92127
(858) 254-4192

Client Information

Today's date: _____

Name: _____

Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Permission to leave a message/text? ◉ Yes ○ No

Highest level of education: _____

Marital Status: _____

What is your current living situation, and whom do you live with?

_____

Referral source (please check):

☐ Personal or professional referral (who) _____

☐ Google search

☐ Website

☐ Your insurance company

☐ Other (who or where): _____

Medical/Psychiatric conditions:

Do you have any known allergies? ◯Yes ◯No

If so, please list your allergies: _____

Are you currently receiving medical or psychiatric care? ◯Yes ◯No

If so, which medical/psychiatric conditions are you being treated for? _____

_____

Are you currently taking any prescription medications? ◯Yes ◯No

If so, which medications are you taking, and for what? _____

_____

_____

Are you currently, or have you in the past received counseling/psychotherapy? ◯Yes ◯No

If so, what issues have you addressed? _____

_____

What types of problems are you currently experiencing? (Please check all that apply)

☐Anxiety ☐Addiction ☐Depression ☐Relationship conflict ☐OCD ☐PTSD ☐Anger ☐Psychosis ☐Physical pain ☐Sexual dysfunction ☐Eating disorder ☐Other _____

Please briefly describe the nature of this/these problems: _____

_____

_____

Which psychological/behavioral issues have you had problems with in the past, and what was the outcome?

_____

_____

_____

Who else is affected by your current problems? _____

_____

On a scale of 1-10, how motivated are you to change your current problems? __1

On a scale of 1-10, how confident are you that you will be successful in changing your current problems? _1 _

Is there anything else you would like me to know at this time that is important in beginning our work together? _____

_____

_____