ADVOCATE PSYCHOTHERAPY SERVICES

SERVING ALL OF CENTRAL WISCONSIN — TO HELP YOU FIND WHAT'S MISSING

Toll Free: 800-681-2374 **Mailing Address:** PO Box 959, Stevens Point, WI 54481 **Fax:** 715-952-4995
Email: office@advocatepsychotherapyservices.com **Website:** www.advocatepsychotherapyservices.com

CLIENT DATA SHEET

Client Name:_____ DOB:_____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

Home #:_____ Work #:_____ Cell #:_____ *(circle preferred #)*

Marital Status:_____ Date of Marriage (if applicable):_____ # of Children:_____

Emergency Contact:_____ Phone:_____

Referral Source:_____ Religious Preference (optional): _____

Primary Care Provider:_____ Location:_____ Phone:_____

Date of Last Exam:_____ Is there anyone else you would like involved in your care?: YES* NO

Place of Employment:_____ *If yes, please list: _____

Occupation:_____ Education:_____

Household Members:

Name	Age	Relationship to You

Medication(s):

Medication Name	Dosage/Time	Reason	Prescribing Physician	Currently Taking

Past Behavioral Healthcare Services:

Name of Therapist/Agency	Date of Services	Reason for Services

(Over)

Presenting Problem (Current Situation and History)

A. Marriage or Relationship
B. Depression
C. Anxiety or Worry
D. Alcohol and/or Drug Use
E. Physical Problems
F. Legal Issues
G. Eating Disorder
H. Problems with Children
I. Work Related
J. Abuse or Trauma
K. Sexual Functioning
L. Financial
M. Other (please explain)

_____

_____

How long have you had this problem(s)?_____

Have you received treatment for this problem: Yes_____ No_____

Desired Goals

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____
5. _____
   _____

_____ _____

Client Signature Date

Addition Info: (staff use only)

_____

_____

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