WISEMAN COUNSELING

Address: 8810 South Yale, Suite P
Tulsa, OK 74137

Phone: (918) 855-1435
Fax: (918) 960-3692

Adult Client Information Form

Date: ______ If you have been a client here before, please fill in only the information that has changed.

A. Identification

Your name: ________________________________ Date of birth: ___________ Age: ________

Your nicknames or aliases: __________________________ Social Security #: ______________

Home street address: ____ Apt.: _____________

City: _____________________________________ State: _________ Zip: _____________

Home/evening phone: _________________ Cell Phone: ____________________________

Calls will be discreet, but please indicate any restrictions: ___________________________________

B. Referral: Who gave you my name to call?

Name: _________________________________ Phone: _______________________________

Address: ____

May I have your permission to thank this person for the referral? Yes No Initial __________

How did this person explain how I might be of help to you? ____________________________

____

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: __________________________________ Phone: _____________________

Address: ____

Current medications: ____

D. Your current employer

Employer: _________________________ Address: ______________________________________

Work phone: __________ Calls will be discreet, but please indicate any restrictions: ______________

E. Your education and training

Dates From	To	Schools	Special Classes?	Adjustment to school	Did you graduate?

F. Employment and military experiences

Dates From	To	Name of military/employers	Job title or duties	Reason for leaving

G. Family-of-origin history

Family Member	Living? (Y/N)	Age	Health Good	Fair	Poor	If deceased, cause of death
Father						
Mother						
Brothers						
Sisters						

Check condition and relationship of any blood relative who has or or has had any of the conditions listed below	Mother	Father	Paternal grandfather	Paternal grandmother	Paternal aunt/ uncle	Maternal grandfather	Maternal grandmother	Maternal aunt/ uncle	Siblings	Other ____
Alcoholism/Substance Abuse										
Allergies										
Birth Defects										
Cancer										
Colitis										
Depression										
Heart Attack										
High Blood Pressure										
Migraine										
Mental Illness										
Seizure Disorder										
Mental Retardation										
Learning/Attention Problems										
Suicide/Suicide Attempt										
Other (Specify)										

H. Marital/relationship history

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
First					
Second					
Third					

Date of current marriage: __________ Spouse's name: ____________________ Spouse's age: _____

I. Significant nonmarital relationships

Name of person	Person's age when started	Person's age when ended	Your age when started	Your age when ended	Reasons for ending

J. Children (Indicate which are from a previous marriage/relationship with the letter P in the last column)

Name	Current age	Sex	School	Grade	Adjustment problems?	P?

K. Spiritual Life

Would you like to incorporate spiritual or religious beliefs in your treatment? Yes No Initial ____

Signature: ____________________________ *Date:* ____________________

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.