Client Health Information

Lifeskills Center, Ltd | Susan White, LCSW
800 Main Street, #11 Lower Level, Antioch, IL 60002

Date: Referred by:

Client Name 1: DOB: Gender:

Client Name 2: DOB: Gender:

Marital Status:

Client 1 SSN: Client 2 SSN:

Email:

Name of Legal Guardian (If Minor):

Phone: Ok to leave messages?

Guarantor:

Employer Name: Employer City:

Insurance Company: Phone:

Emergency Contact: Relationship:

Phone: Address:

Do you have children? List their name(s) and age(s).

Have you been in treatment before? Please describe.

When:

Where:

For what:

Do you actively participate in a spiritual life or organized religion? Please describe.

Are you presently considering suicide? Ever attempted suicide?

Are you presently taking medication?

What kind, for what and dosage?

Any adverse reactions to the above listed medications?

Has alcohol abuse or substance abuse ever been a problem?

Do you smoke cigarettes? Do you smoke marijuana?

Do you drink alcohol? If so, how much?

Do you drink caffeinated products? If so, how much?

Describe any medical concerns you have:

Any physical or mental disability? If so, please describe.

Any allergies? If so, please describe.

What is it that you are asking for help with?

When you felt better, how was it different?

Have you felt bad for the last (circle one): 3 6 9 12 months?

Has your eating been affected by your situation? If so, please describe.

Has your sleeping been affected by your situation? If so, please describe.

Anything else I should know about you so I can help?