# CASTILLO SUMI CONSULTING
# CLIENT INFORMATION

| | | |
|---|---|---|
| **Today's Date:** | **Form Completed By:** | |
| **Referral Source:**<br>□ Email Advertisement □ Phonebook Advertisement □ Other Advertisement □ Doctor<br>□ Friend/Relative □ Return visit □ Sign on building □ other | | |
| **Referral Name:** | | |
| **Reason For Seeking Treatment:** | | |
| **Client's Information** | | |
| **Client's Name:** | | |
| **Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Date of Birth:** | **Age:** | **Gender:** □ Male □ Female |
| **Ethnicity:** | **SSN:** | **Home Phone:** |
| **Marital Status:** □ Married- Complete next section □ Single □ Divorced □ Widowed | | |
| **Spouse's Information** | | |
| **Father's Name:** | | |
| **Address:** | | |
| **City:** | **State:** | **Zip Code:** |
| **Email:** | | |
| **Home Phone:** | **Work Phone:** | **Cell:** |
| **Occupation:** | | |
| **Company:** | | |
| **Company Address:** | | |
| **Date of Birth:** | **SSN:** | **Ethnicity** |
| **Guarantor's Information** | | |
| **Responsible Party/Guarantor Name:** | | |
| **Driver's Lic State & #** | **SSN:** | **Date of Birth** |
| **Employer's Name:** | | |
| **Employer's Address:** | | |
| **Phone:** | **Fax:** | |
| **Insurance Information** | | |
| **Insured Employer:** | | |
| **Insurance Carrier:** | **Relationship to Client:** | |
| **Group #** | **Member #:** | |

| Client's Name: |
|---|
| DOB: |

| Emergency Contact Information | | |
|---|---|---|
| **Name of nearest relative:** | | |
| **Relationship:** | | |
| **Home Phone:** | **Work Phone:** | **Cell:** |
| **Physician's name:** | | |
| **Address:** | | |
| **Phone:** | **Fax:** | |

## Background Information

### Living Situation

| **Primary language at home:** | **Other language spoken at home:** |
|---|---|

| **List names of those who live at home** | **Age (optional)** | **Relation to Client** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

### Medical Information

| | | | |
|---|---|---|---|
| **Allergies:** | □ Yes □ No | **If yes, list:** | |
| **Medical condition:** | □ Yes □ No | **If yes, list:** | |
| **Surgeries:** | □ Yes □ No | **If yes, list:** | |
| **Seizures:** | □ Yes □ No | **If yes, is it recurring:** | □ Yes □ No |
| **Bumps to head requiring medical attention:** | □ Yes □ No | **If yes, when:** | |
| **Emergency room visits:** | □ Yes □ No | **If yes, reason and when:** | |
| **Hospitalizations** (other than surgeries): | □ Yes □ No | **If yes, when:** | |

### Trauma History

| | | | |
|---|---|---|---|
| **Sexual Abuse** | □ Yes □ No | **Physical Abuse** | □ Yes □ No |
| **Witness violence** | □ Yes □ No | **Neglect** | □ Yes □ No |
| **Guns in the home** | □ Yes □ No | **Other** | □ Yes □ No |

| Client's Name: |
|---|
| DOB: |

## Substance Use History

**Are you in recovery for any addiction?** ☐ Yes ☐ No **Type of addiction:**

| Substance Use | Past | How much | Frequency | Current | How much | Frequency |
|---|---|---|---|---|---|---|
| Alcohol | | | | | | |
| Marijuana | | | | | | |
| OTC | | | | | | |
| Prescribed Meds | | | | | | |
| Other: | | | | | | |
| Other: | | | | | | |
| Other: | | | | | | |

## Family History

| | | | | | |
|---|---|---|---|---|---|
| ☐ | No Information Available | ☐ | No significant medical history | ☐ | No significant mental health history |
| ☐ | Seizures | ☐ | Anxiety | ☐ | Depression |
| ☐ | Suicide | ☐ | ADHD | ☐ | Bipolar |
| ☐ | Substance abuse | ☐ | Tics- Motor or Vocal | ☐ | Psychosis |
| ☐ | Learning Disability | ☐ | Other: | ☐ | Other: |

## Service/Treatment History

### *Psychiatric Treatment*

***Are you currently receiving any mental health services?*** ☐ Yes- If yes, complete the info below ☐ No- Skip this section

***Have you currently on any medication?*** ☐ Yes- If yes, complete the info below ☐ No

| Medication | Purpose | Dosage | Prescribing Doctor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| *Service* | *Provider* | *Start Date* | *Frequency* | *Duration* |
|---|---|---|---|---|
| **Individual Therapy** | | | | |
| **Group Therapy** | | | | |
| **Family Therapy** | | | | |
| **Substance Abuse** | | | | |
| **Other:** | | | | |

## Desired Goals

**What are your goals/priorities for treatment?**

***Thank you for taking the time to answer these questions!***