Melissa M. Marciano, LMHC, NCC

Licensed Mental Health Counselor #15410

National Certified Counselor

Confidential Client Information

The following information will be kept as a part of your confidential records. Please fill out as completely as possible.

Name Social Security Number Date

Address City State Zip Phone#

Age_____ Date of Birth_____ Partner Status_____

Occupation_____ Employer_____ Years_____

Education_____

May I contact you at work?_____ Work Number_____

Briefly describe your reasons for seeking services at this time:_____
_____
_____
_____

Have you ever received services for this or similar reasons in the past? If so, when and where, and what was the outcome?_____
_____
_____
_____

Please list any and all health problems you are currently experiencing:_____
_____

_____
_____

When was the last time you saw your
Physician?:_____
_____

Name of your Physician:_____

Please list all medications; prescribed and/or over the counter of which you are currently taking:_____
_____
_____
_____
_____

Please list family members and significant others:

Name	Relationship	Age	Occupation

Please circle any that have been of concern to you in the last 30 days:

Nervousness	Feeling worthless, Depressed	Suicidal Thoughts
Shyness	Sexual Problems	Financial Issues
Unsure of abilities	Divorce/End of Relationship	Lack of Friends
Eating Problems	Loss of self-control	Unhappiness
Alcohol Use	Stress	Work Issues
Drug Use	Headaches	Fatigue
Guilt	Memory Problems	Anger
Fear of Failure	Inferiority feelings/Nightmares	Health Problems
Concentration problems	Marriage/Relationship Issues	Children

Sleep Disturbance	Feeling Empty	Anxiety
Legal Matters	Obsessions	Temper
Sexual Orientation	Education	Body Image
Weight	Self-Esteem	Loneliness
Parent(s)	Hearing Voices	Exercise
Hopelessness	Tearfulness	Seeing strange things

Have you or anyone in your family ever experienced mental health problems, drinking problems, drug addiction, depression or anxiety?? Please describe:_____
_____
_____
_____

If you use alcohol, how many drinks per week?_____ Have you been drinking more lately?_____

How much caffeine (coffee, tea, cola, chocolate, etc) do you drink/eat in a typical day?_____

Time of day that you consume the caffeine?_____

Any recent changes in your eating habits?_____ If so, please describe:_____
_____
_____

List any other kinds of drugs you have used, legal or illegal:_____
_____
_____

Has anyone mentioned or made comments about your drinking, drug use, or eating habits recently?_____. If so, please describe:_____
_____

_____
_____

Were you referred to this office, and by whom?_____

If this person was a professional do I have your permission to confirm with this individual that you came for an appointment?_____

Whom should I contact in case of an emergency?_____

Relationship:_____ Phone Number:_____

Appointments are reserved specifically for you. Therefore, you will be responsible for payment of appointments that are not cancelled 24hrs in advance, unless they are caused by situations both you and I would define as an emergency.

Client Signature Date