RAWN MARTIN, LCSW-C
101 E. Chesapeake Ave., Suite 401
Towson, Maryland 21286

Client Information

Date: ____________________

Name: ____

Address: ____

Social Security No.: ____

Telephone No.: (H) ________________________________ (W) __________________________________

Age: _____ Date of Birth _____________________ Place of Birth ___________________________

Check as many as apply: Committed Relationship _____ Single _____ Divorced _____ Separated _____

Highest level of education attained: _________________________________

Name of child/children:	Age:	Date of birth:
_____________________________	____________	_____________________________
_____________________________	____________	_____________________________
_____________________________	____________	_____________________________
_____________________________	____________	_____________________________

Have you ever been involved in therapy or any other type of counseling program? ☐Yes ☐No

If yes, when? ____________________ Where? ____

Reasons: ____

Reasons for considering counseling at this time: ____

____

Were you referred to this counseling office? ☐Yes ☐No If yes, by whom? __________________________

Are you in treatment with another counselor presently? ☐Yes ☐No

If yes, with whom? Name: ____________________________How long? __________________________

Have you ever been hospitalized for any mental health reason? ☐Yes ☐No

If yes, when? ______________________________ Where? ______________________________________

Reason: ____

Are you receiving medical treatment from a psychiatrist? ☐Yes ☐No

If yes, with whom? Name: __________________________________ Phone ________________________

Have you ever, or are you now being treated by any type of chemical dependency abuse? ☐Yes ☐No

If yes, when? ____________________ Where? ____

By whom? ______________________ Length of treatment _____________________________________

Are you using any type of chemical substance at this time? ☐Yes ☐No

If yes, please indicate what you are using: ____

How frequently do you use these substances? ____

Are you presently under a physicians care for physical problems? ☐Yes ☐No

If yes, please list reasons and any medications: ____

____

Name of family physician: _______________________________ Phone: ______________________________

What problems are you experiencing at this time? ____

____

____

What do you expect from therapy? ____

____

____

Please list everyone with whom you presently live: ____

____

____

What resources do you have (internal and external) that help you feel a bit better when you think about them?____

____

____

Person to contact in case of an emergency: _______________________________ Phone: ________________

Address: ____

____

_____________________________________ Date:_____________________________

(Signature)