Northwest Counseling
Individual and Family Therapy

CLIENT UPDATE FORM

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Primary Insurance Company: ____
Effective Date: _______________
(If policyholder is different than client information above):
____
First Name MI Last Name Social Security # _____________________________________
Address: ____
DOB: _________________________
Relationship to Client: ________________________
Employer: _______________________________________

Secondary Insurance Company: ____________________________________
Effective Date: _________________
(If policyholder is different than client information above):
____
First Name MI Last Name Social Security # ______________________________________
Address: ____
DOB: __________________________
Relationship to Client: ________________________
Employer: ____

It is your responsibility to inform Northwest Counseling of changes in address, phone #, and insurance coverage.

Birth Date: _____/_____/_ Age:______ Gender: Male/Female
Name:____
Address (Street and Number):____
City: __________________ State: ___________________ Zip: ______________
Home Phone: (_____) _____-________
May We Leave a Message

- Yes
- No

Cell/Other Phone: (_____) _____-________
May We Leave a Message

- Yes
- No

How do you want to receive appointment reminders?

- Email
- Text
- Phone
- I do not need reminders

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E-mail:
May We Email You?
- Yes
- No

*Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation:
Place of Employment:_____________________________________
Work Number: (_____) _____-________
If needed, is it OK to call here?
- Yes
- No

Emergency Contact:
Name:____
Relationship:_____________________________________
Phone Number: (_____) _____-________

Have you previously received any type of mental health services since the last time you were seen at this location?

- Yes
- No

If yes, which of the following:

- Psychotherapy
- Medication
- Outpatient Hospitalizations
- Inpatient Hospitalization

If yes, please provide:

Name of provider or facility:____

Briefly, what brings you in today:

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. If you have a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your health.

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Medication/Supplement	Dosage	Condition	Date Began/Stopped

Prescribing provider and contact information:

Name: ____

Specialty: ____

Facility: ____

Phone, email, or Fax:
____

Current Use of Alcohol/Drugs

Circle average weekly alcohol intake:
- None
- 1-3 drinks
- 4-8 drinks
- More than 8

Circle recreational/mood enhancing nonprescription drug use:
- None
- Daily
- Weekly
- Monthly

Circle Type of Drug Used:
- Cannabis
- Cocaine
- Painkillers
- Speed
- Methamphetamine
- Other___________________________________

In the last year have you experienced any of the following:

Picked up or charged with a drug-related driving offense?
- Yes
- No
- Don't know

Lost time from school or work because of use?
- Yes

- No
- Don't know

Experienced a medical problem because of use?
- Yes
- No
- Don't know

Been fired from a job because of use and its effects?
- Yes
- No
- Don't know

Felt you ought to cut down on your drinking or drug use?
- Yes
- No
- Don't know

Had people annoy you by criticizing your drinking or drug use?
- Yes
- No
- Don't know

Felt bad or guilty about your drinking or drug use?
- Yes
- No
- Don't know

Had a drink or used drugs as an eye opener first thing in the morning to steady your nerves or get rid of a hangover, or to get the day started?
- Yes
- No
- Don't know

My average daily nicotine use is: ____
My average daily caffeine use is: ____

Please describe current use of alcohol, cigarettes, and/or recreational drugs:

Please describe previous use of alcohol, cigarettes, and/or recreational drugs:

Are you experiencing, or have you experienced, any of the following since you were last seen at Northwest Counseling?

Financial stress	Yes	No	Don't Know
Relationship stress	Yes	No	Don't know
Housing	Yes	No	Don't know
Health stressors	Yes	No	Don't know
Occupation/employment	Yes	No	Don't know
Legal	Yes	No	Don't know
Education	Yes	No	Don't know
Other: Please list			