Client Information

Date: ______________________________

Client Name: ______________________________

My goal for counseling is: ______________________________

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Is there any family history of tobacco use/abuse, alcohol use/abuse, drug or substance use/abuse, and/or mental illness? If yes, please explain: ______________________________

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Current Medical Conditions: ______________________________

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Current Medications: ______________________________

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Prescribing Physican: ______________________________

Address: ______________________________

Phone Number: ______________________________

333 South 132nd Street ✸ Omaha, NE 68154 ✸ (402) 330-2024 ✸ Fax (402) 697-7019

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