

**Helen Hill MFT**

2211 Corinth Avenue,. Suite 203, Los Angeles, California 90064 / (310) 779-7795

**Confidential Client Information**

Date: Referred by: Therapist:

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Client Name Age: Date of Birth:

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Home Address:

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Home Phone: Work Phone: Other:

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Insurance Company: Group#  
Phone# Policy#

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Social Security Number:

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Occupation: Education Level:

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Relationship Status:  Married  Partner  Single  
 Separated  
Divorced

Partner/Spouse Name: Age: Occupation:

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Children's Names and Ages:

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Were you raised by:  both parents  single parent  
 relative  
 other

Mother's Name: Age: Occupation:

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Father's Name: Age: Occupation:

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Brother's and Sister's (names and ages):

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Why are you seeking counseling?

Do you or any of your family members or significant other have a history of:  
(Check all that apply)

Gender Issues     Alcoholism     Drug Abuse (prescription and or street drugs):

Nervous Breakdown:                   Prolonged illness:                   Eating Disorders:

Other:                   If you checked any of the boxes please explain:

Are you taking any medications?                   Yes                   No                  If yes,  
please list:

Medication name	Dosage	Reason for taking it

Do you have any significant physical problems?    Yes                   No   
If yes, please explain:

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Have you had any previous psychiatric care or counseling? Yes  No

If yes, please explain:

Have you ever been hospitalized for a mental disorder, drug or alcohol

problem? Yes  No  If yes, please explain:

Have you, any of your family members or significant other attempted suicide?

Yes  No  If yes, please explain:

Emergency Contact:

Phone:

Relationship to you:

Client Signature

Date