WILMINGTON CARENET COUNSELING CENTER

CLIENT BACKGROUND INFORMATION

Client: _____DOB:_____

Previous medical issues/surgeries (note year): _____

_____

_____

Current medical concerns: _____

_____

Current medications:

Medication: _____Dosage: _____Prescribed by: _____How long: _____

Medication: _____Dosage: _____Prescribed by: _____How long: _____

Medication: _____Dosage: _____Prescribed by: _____How long: _____

Medication: _____Dosage: _____Prescribed by: _____How long: _____

Others: _____

Do you smoke? (Y/N) _____ Packs per day: ____ Do you drink alcohol? (Y/ N)_____ Drinks per day:_____

Have you previously seen a psychiatrist, psychologist, or therapist ? (Y/N) _____If yes, list previous providers:

_____

Do you have a history of substance abuse or addiction? (Y/N)_____If yes, have you sought treatment:_____

_____

Do you have a family history of substance abuse or mental health concerns? _____

_____

Your signature below confirms that the information on this form is complete and accurate.

Client Signature: _____Date:_____

Counselor Signature: _____Date:_____

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