

Client Data Form

On this form, you are asked to provide some basic information about yourself. Please fill in the blanks with the appropriate information. All information provided on this form will be kept ethically and legally confidential. Thank you for your time and patience.

General Contact Information

Today's Date: ___/___/___ Date of Birth: ___/___/___ Age: _____ Social Security # _____

Name: _____ Gender: Male Female Transgender
Last First Middle

Home Phone: _____ - _____ - _____ May we leave a message at this number? Yes or No

Cell Phone: _____ - _____ - _____ May we leave a message at this number? Yes or No

Work Phone: _____ - _____ - _____ May we leave a message at this number? Yes or No

Email Address: _____ May we send mail to this address? Yes or No

Mailing Address: _____ May we send mail to this address? Yes or No

City: _____ State: _____ Zip Code: _____

*If you do not want us to send mail to address above, please provide an alternative form of communication.

**We use an envelope with the return address of Santhi Periasamy, Ph.D. P.L.L.C. 3303 Louisiana St. Suite 200, Houston, TX 77006, when sending out any correspondence.*

Permanent Address (if different than mailing address) _____

Are you currently employed? Yes or No If yes, please list occupation _____

Are you currently a student? Yes or No If yes, please list major _____

Racial/Ethnic Background: Please indicate your racial/ethnic background _____

Sexual Orientation(optional):

- Bisexual
- Gay
- Heterosexual
- Intersex
- Lesbian
- Questioning

Current Relationship Status(please check all that apply):

- Divorced
- Engaged
- Exclusive Partnership/Relationship
- Living Together
- Married/Partnered
- Never Married
- Remarried
- Separated
- Single
- Widowed

Primary Referral Source

- Self
- Friend
- Internet (please list website) _____
- Printed Advertisement
- Other (please list) _____

Have you previously received inpatient care for the following?

Mental Health Treatment Yes or No If yes, with whom and when? _____
Psychiatric Care Yes or No If yes, with whom and when? _____

Have you previously received outpatient care for the following?

Mental Health Treatment Yes or No If yes, with whom and when? _____
Psychiatric Care Yes or No If yes, with whom and when? _____

Present state of health (please check one): Poor Fair Good Excellent

Please list current medications you are taking (prescriptions, OTC medications and herbal supplements):

Please list any significant medical history (surgery, hospitalization, diseases, etc.):

Please check any of the following with which you are currently experiencing difficulty:

- Academic Difficulties
- Alcohol/Drug Concerns
- Alcohol/Drug issues with Parents
- Anger/Irritability
- Anxiety/Fear
- Assertiveness
- Body Image
- Career Decisions
- Concentration
- Cultural Concerns
- Depression
- Disability Concerns
- Eating/Appetite Concerns

- Emotional/Verbal Abuse
- Family issues/Parents/children
- Finances
- Friends
- Gender Identity
- Grief/Loss
- Identity development
- Legal matters
- Loneliness
- Making Decisions
- Parenting
- Physical Abuse
- Physical Complaints

- Pregnancy and related concerns
- Relationship Concerns
- Self-esteem/Confidence
- Sexual Concerns
- Sexual Abuse
- Sexual Harassment
- Sexual Orientation
- Sleep disturbance/Nightmares
- Stress
- Suicidal Thoughts/Attempts
- Unwanted Sexual Experience
- Other (Please specify)

In your own words, please briefly describe what brings you to counseling at this time.

What are your three most significant concerns at this time?

1. _____, 2. _____
3. _____

In imminent danger situations, your therapist is required to act to insure your safety. In these cases, the State only allows us to contact the police or health/mental health personnel to insure your safety. If you would like to give us permission to contact someone else in these situations, please print their name, address, phone number, and the relationship of that person to you in the space provided. Providing an emergency contact person is in your best interest as a client.

Emergency Contact:

Name _____ Phone number _____