RACHEL BENSON
LCSW

Rachel Benson, Licensed Clinical Social Worker, Inc.
Individual, Couples, & Group Psychotherapy

Client Information Sheet

The information requested on this form is completely confidential.

Today's Date: _____

PERSONAL

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Telephone numbers: home_____ work _____

Is it okay to leave confidential messages at the above numbers? Yes No (circle one)

Birthdate: _____ Birthplace:_____

EMPLOYMENT

Employer: _____ Occupation: _____

Employment address: _____

FAMILY HISTORY

Father: ___Living ___Deceased Current age or age at time of death: ____ Cause of death: _____

Mother: ___Living ___Deceased Current age or age at time of death: ____ Cause of death: _____

List birth order of your siblings, including yourself, indicating number of years between you (see example):
(Example: Older Brother -- 3 yrs. --- Older Sister --- 1 yr. --- ME --- 2 yrs. --- Younger Brother)

Family Birth Order: _____

Children – How many _____ Names & Ages_____

IN CASE OF EMERGENCY,
PLEASE CONTACT: _____ ***PHONE:*** _____
Name and relationship

REFERRED TO THIS OFFICE BY: _____

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PSYCHOTHERAPY, MEDICAL, AND MEDICATION HISTORY

Have you ever sought psychotherapy or counseling before? Yes No (circle one)

If so, when? _____ For how long? _____

Please list all medications you are currently using: _____

_____

Apart from those medications listed above, have you ever used any of the following:

Anti-depressants	Yes	No (circle one)	Anti-anxiety meds	Yes	No
Appetite suppressants	Yes	No	Laxatives	Yes	No
Sedatives	Yes	No	Muscle relaxants	Yes	No
Pain medication	Yes	No			

Have you ever been hospitalized for any reason? Yes No (circle one)
If so, when? _____ For how long? _____

If so, please explain the situation: _____

Do you have any current or past medical issues? Yes No (circle one)

If yes, please explain: _____

ADDITIONAL INFORMATION

I am currently: (circle all that apply) Single Dating someone Engaged Married Divorced Widowed

If in a relationship, how long have you been in your current relationship? _____

If in a relationship, on a scale from 1-10, how would you rate your current relationship? _____

How do you identify your gender?_____ What is your sexual orientation? _____

What significant life changes or stressful events have you experienced recently?

_____

_____

What would you like to accomplish out of your time in therapy?

_____

_____

_____

CANCELLATION POLICY

To avoid being charged for a cancelled session, the session must be cancelled at least 24 hours in advance by leaving a message at (714)-468-3685. Sessions cancelled with less than 24 hours notice will be charged at the full fee. By law, insurance providers may not reimburse patients for fees paid for cancelled sessions.

POLICY AND LAWS REGARDING CONFIDENTIALITY

All information between patient and therapist is held in strict confidence. The only exception to this is that state law requires all mental health providers to report suspected child or elder abuse, and allows for breach of confidentiality if patients disclose a likelihood to be of danger to themselves or others.

I have read the foregoing and my signature below attests to my understanding of these policies.

Signature **Date**