Client Information

CONFIDENTIAL

Date_____

Name _____ DOB _____ Age _____ Sex _____
Address _____ OK to send mail? _____
City _____ State _____ Zip _____ OK to phone/text? _____
Phone _____ Work Phone _____ OK to leave message? _____
Email _____ OK to email? _____
Employer _____ Position _____

Relationship Status: ___ Minor ___ Single ___ Married ___ Separated ___ Divorced ___Widowed
Partner's Name (if applicable) _____ Employer _____
Names & Ages of Children (if applicable) _____
_____

Emergency Contact _____ Relationship _____
Address _____ City _____
State _____ Zip _____ Phone _____ Work Phone _____
OK to leave a voice message? _____ Email _____

Religious background and/or current affiliation (if any) _____
_____

Current Physician(s): Name, Address, and Phone _____
_____
_____

Current health concerns _____
_____
_____

Medications you are taking and dosages _____
_____

Reason for seeking therapy _____
_____

Referred by / How you heard about me _____

CONTINUED ON BACK

Dr. Cynthia Kok MSW Ph.D.
LICENSED PSYCHOLOGIST
Cynthia Kok Therapy, Inc. | 983 Spaulding SE Ada MI 49301 | 616.236.3326

Please indicate if/when you have had the following experiences by checking all that apply:

	Never	Sometime in the Past	Within the Past Month
Attended counseling for mental health concerns			
Taken a prescribed medication for mental health concerns			
Been hospitalized for mental health concerns			
Purposely injured yourself without suicidal intent (e.g., cutting, hitting, burning, pulling hair, etc.)			
Seriously considered attempting suicide			
Made a suicide attempt			
Considered seriously injuring another person			
Been concerned about your alcohol, nicotine or drug use			
Had unwanted sexual contact(s) or experience(s)			
Experienced harassing, controlling, and/or abusive behavior from another (e.g., friend, family member, partner, or authority figure)			
Experienced a traumatic event			