

Jean L. Hehn, LCSW

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www.jeanhehn.com

Client Information

Today's Date: _____

Client's Name: _____

Street Address: _____

City: _____ State: _____

Zip Code: _____

Social Security Number: _____

Home Phone: () _____ May we leave a message? _____

Cell Phone: () _____ May we leave a message? _____

Work Phone: () _____ May we leave a message? _____

Birth Date: _____ Sex: M or F Marital Status: _____

Employer: _____

Who referred you to Jean Hehn? _____

Would you like to receive occasional 2-3x per year emails from Jean on general topics of interest? If so give your email address: _____

Client History

List everyone in your household:

First Name	Last Name	Age	Educ Level	Relationship to Client

Describe your current physical health or list current health problems: _____

Physician's Name and Address: _____

Are you currently taking any medication? If so, please list: _____

Are you allergic to any medications? If so, please list: _____

Have you ever had major surgery? If so, please list: _____

Have you ever had:

High Fever _____ Head Injuries _____ Seizures _____

High Blood Pressure _____ Thyroid Condition _____ Heart Problems _____

Do you smoke? _____ Do you use or abuse alcohol? _____

Do you use other intoxicants? _____

Do you have family members who use or abuse alcohol? If so, please explain: _____

Do you have a family history of mental health concerns such as depression, anxiety, bi-polar, etc.? If so, please explain. _____

What problems do you have at this time for which you are seeking assistance? _____
