ALPHA OMEGA CLINIC AND CONSULTATION SERVICES
P: 301-767-1733 / F: 301-767-1743

7007 Bradley Blvd	3607-A Chain Bridge Rd	108 N. Payne St	5034 Dorsey Hall Dr, Ste 202
Bethesda, MD 20817	Fairfax, VA 22030	Alexandria, VA 22314	Ellicott City, MD 21042

CLIENT INFORMATION FORM

Date:_____

Client Name:_____ Date of Birth:_____
Address: _____
City: _____ State: _____ Zip: _____
Email Address: _____
Primary Phone: _____ Type: ☐ Cell ☐ Home ☐ Work ☐ Other
Messages: ☐ No Messages ☐ Voice Messages OK ☐ Text Messages OK
Secondary Phone: _____ Type: ☐ Cell ☐ Home ☐ Work ☐ Other
Messages: ☐ No Messages ☐ Voice Messages OK ☐ Text Messages OK

Employment:
☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed/Other

Marital Status:
☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Religious Affiliation:
☐ Catholic ☐ Protestant ☐ Jewish ☐ Muslim ☐ Hindu ☐ Buddhist ☐ Other _____

Spouse Name: _____ Date of Birth: _____
Primary Phone: _____ Type: ☐ Cell ☐ Home ☐ Work ☐ Other
Secondary Phone: _____ Type: ☐ Cell ☐ Home ☐ Work ☐ Other

Guardian Name: _____ Date of Birth: _____
Primary Phone: _____ Type: ☐ Cell ☐ Home ☐ Work ☐ Other
Secondary Phone: _____ Type: ☐ Cell ☐ Home ☐ Work ☐ Other

Emergency Contact Name: _____ Relationship: _____
Primary Phone: _____ Type: ☐ Cell ☐ Home ☐ Work ☐ Other
Secondary Phone: _____ Type: ☐ Cell ☐ Home ☐ Work ☐ Other

How did you become aware of Alpha Omega Clinic?
☐ Friend ☐ Relative ☐ Priest/Parish ☐ School ☐ Website ☐ Other _____

What concerns do you want to discuss with your clinician? [Check all that apply]
☐ Adolescents ☐ Anger Management ☐ Anxiety ☐ Behavioral Problems ☐ Child Rearing
☐ Communication ☐ Compulsions ☐ Depression ☐ Discipline ☐ Divorce/Separation
☐ Domestic Violence ☐ Eating Disorder ☐ Educational Testing ☐ Loss/Grief ☐ Marital Issues
☐ Post-Abortion ☐ Pornography Addiction ☐ Psychological Testing ☐ Relationships
☐ Sex Addiction ☐ Sexual Abuse/Rape ☐ School Adjustment ☐ Scrupulosity
☐ Stress Reduction ☐ Substance Abuse ☐ Trauma/PTSD ☐ Work Related Issues ☐ Other

Are your spiritual beliefs/practices important in your day-to-day life? [Check one]
☐ Very Important ☐ Somewhat Important ☐ Not Important

Do you want your clinician to integrate your faith into your treatment? [Check one]
☐ Yes ☐ No ☐ Unsure

Previous Mental Health Treatment:
☐ Psychotherapy ☐ Hospitalization Reason: _____ Date: _____
☐ Psychotherapy ☐ Hospitalization Reason: _____ Date: _____
☐ Psychotherapy ☐ Hospitalization Reason: _____ Date: _____
☐ No Previous Treatment

Current Medications:

1. Name: _____ Reason: _____

   Prescribing Physician: _____

2. Name: _____ Reason: _____

   Prescribing Physician: _____

3. Name: _____ Reason: _____

   Prescribing Physician: _____

4. Name: _____ Reason: _____

   Prescribing Physician: _____

☐ No Medications

Other Concerns: Is there anything else you want your therapist to know? _____

_____

_____