Lauren Drago Therapy
Lauren LaRusso Drago, MSEd, LPC, LMHC
(914) 288-6552
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NY License #: 006885-1

Client Information Form

Thank you for taking the time to complete this questionnaire. Please answer the questions below as best you can. The answers you provide here help pull together a lot of information quickly so that I can be well informed before we start finding solutions to your concerns. The information you provide here is protected as confidential according to the law. If you feel uncomfortable answering anything, please feel free to leave the answers blank, and/or bring up any questions, concerns, or discomfort with me.

Today's Date:

Name of Client: Client Birth Date: Client Age:

Name of Guardian if Applicable:

Client/Guardian Address:

Home Phone: Work Phone:

Cell Phone:

Preferred Email:

Is it okay for me to send mail to your address if necessary? Yes / No

Is it okay for me to leave you a voicemail if necessary? Yes / No

Is it okay for me to email you regarding non-clinical matters (ie: scheduling)? Yes / No

*Please note that email and text are **NOT** confidential forms of communication. I strongly discourage addressing clinical information, concerns, and matters in these ways.*

Client/Guardian Occupation:

Employer:

Employer Address:

Client Gender Identification: Client Preferred Pronouns:

Client/Guardian Relationship Status:

Client/Guardian Partner's Name (if applicable):

Client/Guardian Children Names, Gender and Age(s) (if applicable):

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Other Persons Living with You (Names, Ages & Relationship to you):

How did you hear about Lauren Drago Therapy?

Emergency Contact:

Name: Relationship:
Phone: Email:

Address:

Is emergency contact aware that you are engaged in therapy? Yes ☐ No ☐

Please indicate prescription medications client has taken/are taking for emotional, mental or psychiatric concerns:

Medication	For What?	Results?	When/How long?	Prescribing Doctor/Phone?

Has client ever been hospitalized for mental health reasons? Yes ☐ No ☐
Has client ever been hospitalized for substance abuse reasons? Yes ☐ No ☐
If yes, please indicate the dates/length of your stay: _____
Has client had any past or recent thoughts of self-harm or suicide? Yes ☐ No ☐

Is client **currently** seeing a therapist? Yes ☐ No ☐
If yes: Individual Therapy_____ Group Therapy _____ Family Therapy _____
Marital/Couples Therapy _____(check all that apply)
If yes: Since When? _____
Therapist's Name & Telephone _____
Has client received counseling/therapy in the **past?** Yes ☐ No ☐
If yes: Individual Therapy____ Group Therapy _____Family Therapy ____ Marital /Couple Therapy_____
If yes: Begin / End (Years) ___

I affirm all of the above information:

_____ _____
Client or Guardian Name **Client or Guardian Signature** **Date**