Tina Champagne OTD OTR/L For Cutchins Care LLC

Client History Form

Name: Birth Date: Gender:

Married/Children/Living Arrangements:

Employment/School:

Current Reason for Referral:

Past Therapy/Therapists/Inpatient/Outpatient:

Substance Abuse Issues Or Treatment:

Medical Issues Effecting Health:

Family Physical or Mental Health History Possibly Contributing to Situation:

Symptoms:

Social Connections or Supports and Client Strengths:

Typical Diet In A Three Day Period:

Prescribed or Recreational Drugs and Supplements:

PCP Name and Contact Information:

Psychiatrist Name and Contact Information: