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Client Information Form

Date: _____ Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Other phone: _____
Ok to leave message?:__ __ __

Date of Birth: _____ Age: _____ Gender: __ M __ F

Marital Status: __ Never married __ Married __ Separated __ Divorced __ Widowed

Religion:_____

Employer Name: _____

Employer Address: _____

Referred by: _____

Have you been in therapy before? __ Yes __ No When and for how long? _____

Who was your previous therapist? _____

Have you ever been evaluated by a psychiatrist for medication? __ Yes __ No

Psychiatrist's Name? _____ When? _____

What was the reason? _____

Medications and dosages prescribed by psychiatrist or other doctor for emotions or behavior

_____, _____, _____

Have you ever been hospitalized for mental health issues? __ Yes __ No When? _____

Where? _____ For how long? _____

Primary Complaints at this Time

Please check **all** that apply:

___ Depression	___ Substance Abuse	___ Eating Problems
___ Anxiety	___ Sexual Dysfunction	___ Panic Attacks
___ Post-Traumatic Stress	___ Relationship Problems	___ Medical Crisis
___ Attention Problems	___ Grief/Loss	___ HIV/AIDS
___ Suicidal/Homicidal Thoughts	___ Adjustment to New Situation	___ Tic Disorder
___ Habits or obsessions	___ Sleep Problems	___ Other

Insurance Information

Insurance co: _____ Card Holder's Name: _____

Insurance ID #: _____ Group #: _____

Insurance company telephone number: _____

Emergency Contact Information

In case of emergency, whom should I contact? _____

Relationship to you: _____

Phone numbers: _____