CLIENT NAME: _____ CLIENT DOB: _____

Confidential Client Information Form

Contact Information (Adult Client or Parent-Legal Guardian)

Date: _____ OK to send mail?

Name: _____ Yes No

Birth Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

	OK to call?		OK to leave message?	
Home Phone: _____	Yes	No	Yes	No
Cell Phone: _____	Yes	No	Yes	No
Work Phone: _____	Yes	No	Yes	No

OK to email?

Email: _____ Yes No

Please provide a name and phone number of whom to call in case of an emergency?

_____

Client Information Form

Demographic Information

Gender:_____ Ethnicity:_____Race:_____

Disability Status: _____

Partner(s)/Relationship Status:_____

Occupation/Employer:_____

Referral Information

Who referred you? _____

Current reason(s) for seeking therapy?

_____

Estimate the severity of the problem for which you are seeking care:

Mild Moderate Severe Very Severe

How many sessions or how much time do you think you might need to successfully resolve this problem?

1-10 sessions 10-20 sessions Ongoing, Longer-term therapy

Client Information Form

Medical & Insurance Information

(Adult Client or Child Client)

I. Insurance Yes No

A. Primary Insurance

Insurance Provider: _____

Insured Full Name: _____

Insured Member ID: _____

Insured Date of Birth: _____

OHP Open Card: Yes No N/A

Out of Network Coverage: Yes No

Co-Pay Amount: _____

B. Secondary Insurance

Insurance Provider: _____

Insured Full Name: _____

Insured Member ID: _____

Insured Date of Birth: _____

OHP Open Card: Yes No N/A

Out of Network Coverage: Yes No

Co-Pay Amount: _____

Client Information Form

Physician Name: _____ Physician Phone: _____
Date of Last Visit: _____
Relevant medical conditions: (history, current condition, changes in condition)

_____

I. Has Client ever been hospitalized? (If yes, Please provide details):

_____

II. Is Client currently taking any medications? (Please list names, dosages, and prescribing doctor):

_____

III. A. Please list any past/present drug and alcohol use.

_____

B. What have you used and how much?

_____

C. What are you currently using and how much?

_____

D. Has it ever affected your work or relationships?

_____

IV. A. Has Client previously been in therapy?

_____

B. When and for what concerns/issues?

_____

C. Was it helpful? (Why or why not)?

_____

V. Does Client have any previous suicide attempts, self-destructive behaviors, or violent behaviors?

(Indicate age, circumstances, and whether it led to hospitalization or legal problems).

_____

Client Information Form

VI. What are your/Client's main challenges?

VII. What do you consider your/Client's main strengths?

VIII. Please add any additional information that may be helpful to our work together.

Relationships

I. A. Do you/Client live with others? _____

B. Names & Ages _____

C. What is their relationship to you/Client?

_____

II. A. Current Spouse/Partner(s): _____

B. First Name: _____

C. Occupation: _____

D. How would you describe your relationship satisfaction?

III. Are there any other current relationships that are a significant focus in your/Client's life right now? Please describe:

Spiritual Information

Name of person completing this form: _____

Religious/Spiritual preference: _____

How would you like your religious/spiritual preference to be included into the sessions?

Client Information Form

Topics you would like to discuss with your counselor:

Adult Only Specific:

Academic/Learning Difficulties	Suicidal Thoughts/Behaviors	Adjustment Concerns
Physical Complaints	Personal Growth	Smoking
Relationship Concerns	Racing Thoughts	Sleep Problems
Self-Esteem/Self-Worth	Drug Abuse	Death or Grief
Impulsiveness	Alcohol Problems	Social Skills
Eating Patterns/Appetite	Financial Problems	Family Concerns
Feeling of Isolation/Loneliness	Stress/Anxiety/Nervousness	Anger Management
Date rape/Rape/Sexual Assault	Vocational/Career Problems	Marital concerns
Concentration/Memory	Depression/Feeling Low	
Emotional/Verbal/Physical Abuse		

Other:_____

Child Only Specific:

Child Attachment Problems	Separation Anxiety	Behavior Concerns
Social/Emotional Concerns	Eating Concerns	Death or Grief
Sleep Concerns	Depression/Feeling Low	Parenting
Stress/Anxiety/Nervousness	Concentration/Memory	Communication Concerns
Emotional/Verbal/Physical/Sexual Abuse **(Circle All)**		

Other:_____

_____

Client Signature Date

_____

Client Signature Date

_____

Therapist Signature Date

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