

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)

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

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

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

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B. What have you used and how much?

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C. What are you currently using and how much?

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D. Has it ever affected your work or relationships?

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IV. A. Has Client previously been in therapy?

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B. When and for what concerns/issues?

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

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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?

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

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

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### Relationships

I. A. Do you/Client live with others? \_\_\_\_\_

B. Names & Ages \_\_\_\_\_

C. What is their relationship to you/Client?

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II. A. Current Spouse/Partner(s): \_\_\_\_\_

B. First Name: \_\_\_\_\_

C. Occupation: \_\_\_\_\_

D. How would you describe your relationship satisfaction?

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

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### 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?

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## Client Information Form

### Topics you would like to discuss with your counselor:

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#### 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 <b>(Circle All)</b>		
Other: _____		

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Client Signature

Date

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Client Signature

Date

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Therapist Signature

Date