CLIENT INFORMATION FORM

☐Check this box if the client is the financially responsible party. Date: _____

Client Name: _____
(First) (Middle) (Last)

Address: _____
(Number) (Street)
_____
(City) (State) (Zip)

Home Phone: (_____) _____ Social Security #:_____

Work Phone: (_____) _____ Date of Birth: _____

Cell Phone: (_____) _____ Age: _____ ☐Male ☐Female

Email Address: _____ @ _____

Referred By: _____

Current Medications: _____

Primary Care Physician: _____

Address: _____

Phone: (_____) _____ Date of Last Visit: _____

ADDITIONAL INFORMATION FOR PARENT(S)/GUARDIAN(S)
OF MINOR CLIENTS (UNDER AGE 18)

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

_____ _____

Social Security #: _____ Social Security #: _____

Home Phone: (_____) _____ Home Phone: (_____) _____

Work Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Cell Phone: (_____) _____

☐Check if this person is the financially responsible party. ☐Check if this person is the financially responsible party.

_____ _____
Signature of Client or Parent/Guardian* Date

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parents' signatures are required.

_____ _____
Signature of Additional Parent Date

HANDLING OF CONFIDENTIAL INFORMATION

Telephone

Home	**Cell**	**Work**
May I telephone you at your home? Yes No	May I telephone you on your cell? Yes No	May I telephone you at work? Yes No
May I leave messages at your home? Yes No	May I leave messages on your cell? Yes No	May I leave messages at work? Yes No

Written Communication

May I send mail to your home address? Yes No*
*If no, please provide an *alternate* address for mailing:

_____

(Street Address) (City, State) (Zip)

May I communicate with you via email? Yes No
If yes, please provide an email address:_____ @ _____

Advisory Regarding Electronic Communications

It is important that you understand that the nature of modern-day communications undermines your privacy and confidentiality in ways you may not realize. I cannot guarantee your confidentiality when we communicate through email, Internet, cordless or cell phone, or other mobile device. Any communication through these media is vulnerable to being intercepted and overheard by other people. Therefore, if we communicate through one of these media, you should understand that our communication may not be entirely confidential. In order to be as responsive to you as needed outside of our sessions, I may have to respond to you through cell phone, text, or email. However, I attempt to limit such communication to scheduling or other logistics in order to protect your confidentiality.

How do you **prefer** that I contact you?_____

Are there any restrictions for communication with you that I should be aware of? Yes* No
*If yes, please describe:
_____

_____

Name and Telephone of Client Emergency Contact:_____

_____

_____ _____
Signature of Client or Parent/Guardian* Date

_____ _____
Print Name Relationship to Client

_____ _____
Print Client's Name Client's DOB

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parents' signatures are required.

_____ _____
Signature of Other Parent Date

_____ _____
Print Name Relationship to Client

NEW CLIENT PRE-SCREENING QUESTIONS

(If client is a minor, please have parent/guardian respond as appropriate about the minor child.)

Have you received the Notice of Privacy Practices Regarding Protected Health Information?	YES	NO
Have you read and agreed to the Client Services Agreement (CSA)?	YES	NO
Do you understand that, under particular circumstances, we may be required to release information about you without your permission?	YES	NO
Have you (or minor client) ever had a psychiatric hospitalization? *If yes, please provide dates and hospitals?_____	NO	YES*
Have you (or minor client) ever attempted suicide?	NO	YES
Do you (or minor client) ever think about committing suicide or talk about wanting to die?	NO	YES
Do you (or minor client) ever intentionally harm or injure yourself?	NO	YES
Do you (or minor client) ever think about harming or killing someone else?	NO	YES
Have you (or minor client) ever had unusual perceptions or bodily sensations?	NO	YES
Are you (or minor client) currently under the care of another mental health provider? *If yes, please provide name of provider:_____	NO	YES*
Have you (or minor client) ever exercised for longer than an hour at a time, used laxatives, or induced vomiting in order to control your weight?	NO	YES
Are you (or minor client) now, or have you ever been, a victim of violence or abuse? *If yes, by whom and was it reported?_____	NO	YES*
Have you (or minor client) ever been violent or abusive toward someone else?	NO	YES
Has anyone in the family ever been violent or abusive? *If yes, who?_____ and to whom?_____	NO	YES*
Have you (or minor client) ever had, or been told you have, a problem with alcohol or drugs?	NO	YES
Have you (or minor client) ever been arrested or incarcerated?	NO	YES

Specific for clients under age 18

Are the parents of the minor client married to each other?	YES	NO*
*If no, do you have sole or joint custody of the child coming for treatment?	SOLE	JOINT*

*If parents are ***separated*** or ***divorced*** and have ***joint custody***, both parents' signatures are ***required*** on all paperwork.

_____	_____
Signature of Client or Parent/Guardian	Date
_____	_____
Print Name	Relationship to Client
_____	_____
Print Client's Name	Client's DOB
_____	_____
Signature of Other Parent	Date
_____	_____
Print Name	Relationship to Client