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CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your name: _____

Last First Middle Initial

Date of birth: _____ Social Security #: _____

Home street address: _____

City: _____ State: _____Zip:_____

Current Age_____ Gender/Sexual Identity _____

Name of Employer: _____

Address of Employer: _____

City: _____ State: _____Zip:_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Calls will be discreet, but please indicate any restrictions: _____

Referred by: _____

May I have your permission to thank this person for the referral? Yes No

If referred by another clinician, would you like for us to communicate with one another? Yes No

Person(s) to notify in case of any emergency:

_____

Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so:

(Your Signature): _____

Please briefly describe your presenting concern(s): _____

_____

_____

What are your goals for therapy? _____

_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses:

_____

_____

_____

Current Medications:

Medication	Dosage	Purpose	Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day? _____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

Do you use any non-prescription drugs? YES NO If YES, what kinds and how often? _____

_____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons): _____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons): _____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO

(Please list approximate dates and reasons): _____

_____

_____

FAMILY:

How would you describe your relationship with your mother? _____

How would you describe your relationship with your father? _____

Are your parents still married? _____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

_____

Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings? _____

_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ With? (First name) _____

Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO

If yes, length of previous marriages/committed partnerships _____

Do you have Children? ____ If YES, how many and what are their ages: _____

Describe any problems any of your children are having: _____

_____

List the names and ages of those living in your household: _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

Current level of satisfaction with your friends and social support:

POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care: _____

_____

Is spirituality important in your life and if so please explain: _____

_____

Briefly describe your diet and exercise patterns: _____

_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree (or Higher)___ Vocational Degree___

What are your responsibilities with your current employer? _____

_____

Employment Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Any past career positions that you feel are relevant? _____

_____

What do you think are your strengths? _____

_____

PLEASE CHECK ALL THAT APPLY & CIRCLE THE MAIN PROBLEM:

Difficulty with…	Now	Past	Difficulty with…	Now	Past	Difficulty with…	Now	Past
Anxiety			Headaches			People in general		
Depression			Legal problems			Nausea		
Parents			Sweating			Abdominal Distress		
Mood changes			Memory loss			Children		
Fainting			Sexual concerns			Anger or temper		
Marriage/partnership			Heart palpitations			Dizziness		
Friend(s)			Excessive worry			Diarrhea		
Panic			History of child abuse			Fears		
Co-workers			Muscle tension			Shortness of breath		
Irritability			Feeling manic			Employer		
Chest Pain			History of sexual abuse			Concentration		
Finances			Pain in joints			Lump in throat		
Trusting others			Domestic violence			Allergies		
Communicating			Thoughts of suicide			Thoughts of hurting others		
Careless mistakes			Drug/Alcohol abuse			Fidget frequently		
Impulsiveness			Sleeping too much			Insomnia		
Vomiting			Weight gain			Weight loss		
Eating problems			Completing tasks			Easily distracted		
Blackouts			Head injury			Nightmares		
Hyperactivity			Chills or hot flashes			Victim of crime		
Sexual assault			Physical assault			Combat experience		
Natural disaster			Serious accident			Witness upsetting event		
Emotional abuse			Harming self			Sexual orientation/gender		

Any additional information you would like to include: _____

_____

_____

_____

_____

Any questions or concerns about therapy/therapist? _____

_____