



CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your name: _____
Last First Middle Initial

Home street address: _____

City: _____ State: _____ Zip: _____

Date of birth: _____

Name of Employer: _____

Address of Employer: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

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

Email: _____

Periodically I send emails with helpful information about healthy relationships, new clinical research findings and special events.

Please check if you would like to opt out of these communications.

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:

Name of Medication	Dosage	Purpose	Name of 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): _____

Height _____ Weight (if applicable) _____ Age _____ Gender _____

Sexual & Gender Identity: Heterosexual Lesbian Gay Bisexual Transgender

Asexual In Question Other: _____

Racial/Ethnic Identity:

African/African-American/Black Latino/Latino-American Bi-Racial/Multi-Racial

American Indian/Alaska Native Middle Eastern/Middle Eastern-American

Asian/Asian-American/Asian Pacific Islander White/European-American Not listed

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

Married/Life Partnered? _____ How Long? _____

Previously Married/Life Partnered? YES NO

If so, 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 is your current employment? _____

POOR Employment Satisfaction: 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 →			People in General →			Nausea →		
Depression			Parents			Abdominal Distress		
Mood Changes			Children			Fainting		
Anger or Temper			Marriage/Partnership			Dizziness		
Panic			Friend(s)			Diarrhea		
Fears			Co-Worker(s)			Shortness of Breath		
Irritability			Employer			Chest Pain		
Concentration			Finances			Lump in the Throat		
Headaches			Legal Problems			Sweating		
Loss of Memory			Sexual Concerns			Heart Palpitations		
Excessive Worry			History of Child Abuse			Muscle Tension		
Feeling Manic			History of Sexual Abuse			Pain in joints		
Trusting Others			Domestic Violence			Allergies		
Communicating with Others			Thoughts of Hurting Someone Else			Often Make Careless Mistakes		
Drugs			Hurting Self			Fidget Frequently		
Alcohol			Thoughts of Suicide			Speak Without Thinking		
Caffeine			Sleeping Too Much			Waiting Your Turn		
Frequent Vomiting			Sleeping Too Little			Completing Tasks		
Eating Problems			Getting to Sleep			Paying Attention		
Severe Weight Gain			Waking Too Early			Easily Distracted by Noises		
Severe Weight Loss			Nightmares			Hyperactivity		
Blackouts			Head Injury			Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems	<input type="checkbox"/>	<input type="checkbox"/>	Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Legal Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	“Nervous Breakdown”	<input type="checkbox"/>	<input type="checkbox"/>

Any additional information you would like to include:
