CLIENT INFORMATION FORM

Please provide the following information below. Note: information you provide here is protected as confidential information. ***Please complete this form and bring it to your first session.***

Client Name (first, last)____Today's Date _____________

Client Address: ____

Phone: Home ______________________Cell: ________________________ Work:____________________

E-mail: ___________________________ Best way to leave message: Home Cell Work E-mail

Birthdate: ________________ Age: _____ Gender: Male Female

Ethnicity: ____

Relationship Status: Married____yrs Serious relationship ____yrs Divorce _____yrs Separated

Children? Yes, ages _____________________________ No Driver's License #___________________

Current Occupation:____

Work Address: ____

Student? No Yes, school name: ____

Referred by (if any): ____

Emergency Care Information

Personal Physician: Name: ___________________________________Phone: ________________________

Address:____

Family and/or friends to be contacted in an emergency:

Name: ____Phone: ____________________

Name: ____Phone: ____________________

Previous Psychotherapy or Counseling

Name of therapist	City/phone number	Treatment dates
_______________________	____________________________	____________________
_________________________	______________________________	____________________

Describe the problems for which you sought therapy in the past:

____

____

Was your experience with previous therapy: Positive Neutral Limited Negative

Have you been hospitalized for psychiatric problems? No Yes, (#) ____ times, year(s) _____________

Have you been hospitalized for substance abuse problems? No Yes, (#) ____ times, year(s) _______

Have you ever purposefully injured yourself WITHOUT suicidal intent (e.g., cutting, hitting, burning, etc.)? No If Yes, when ________ _____________, and how often ____________________________

Please describe: ____

Have you seriously considered attempting suicide in the past? No If Yes, when ________________

Have you made a past suicide attempt? No If Yes, when _____________________________________

Have you had any of these traumatic experiences?

___Childhood sexual abuse ___Sexual assault by a stranger ___Witnessing trauma/death

___Acquaintance or date rape ___Serious physical injury ___Other: _______________

Have you experienced harassing, controlling, and/or abusive behavior from another person? No Yes

If yes, please describe: ____

Current Concerns

Please provide a brief description of the major concerns that led you to seek therapy at this time.

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General Health and Mental Health Information

Do you have any existing medical problems or any current physical symptoms of concern to you? If so, please describe:

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Current Medications:

Type of Medication

________________________ ________________________ ________________________

________________________ ________________________ ________________________

Please indicate any major illnesses, accidents, and/or hospitalizations within the last 5 years:

____
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Do you smoke? No Yes, (#) _____ per day Do you drink alcohol? No Yes, (# drinks) ______per week

Do you engage in any other substance/drug use? No Yes, explain_____________________________

Do you exercise? Regularly Occasionally Rarely Never

How would you rate your current sleeping habits? Excellent Good Fair Poor

How is your general health? Excellent Good Fair Poor

Are you currently experiencing overwhelming sadness, grief, or depression? No Yes

If yes, for approximately how long? ______________________________________

Are you currently experiencing anxiety, panic attacks, or have any phobias? No Yes

If yes, when did you being experiencing this? ______________________________

Family Background

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (e.g., father, grandmother, uncle, etc)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Eating Disorders	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

Social/Occupational/Family Functioning

How is your social network? No close friends One close friend Few friends Many friends

How often do you make contact with friends? Regularly Occasionally Infrequently Never

Are you currently in a romantic relationship? No Yes, it is…. Generally Positive Neutral Problematic

Are you able to talk to others about the concerns that bring you to therapy? No Yes

What is your living situation? Live alone Live with others, with whom? ______________________

Are you currently employed? No Yes, it is …. Very Satisfying Mostly satisfying Mixed Unsatisfying

Do you consider yourself to be spiritual or religious? No Yes, please describe your faith or belief:
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Goals

Please describe the goals you would like to accomplish during your time in therapy:

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