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Client Information Form

Legal Name: _____ Date: _____

Preferred Name: _____ Age: _____

Address: _____ Date of birth: _____

_____ Preferred Pronouns: _____

Contact		Ok to leave Message/email?	
Hm:	_____	☐ Yes	☐ No
Cell:	_____	☐ Yes	☐ No
Work:	_____	☐ Yes	☐ No
Other:	_____	☐ Yes	☐ No
Email:	_____	☐ Yes	☐ No

Emergency Contact

Name: _____ Relationship to you: _____

Phone: Hm: _____ Wk: _____ Cell: _____

Address: _____

Referral Information

How did you hear about my services: _____

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

Reimbursement

Would you like statements provided to you each month that you can forward to your insurance company to request reimbursement? ☐ Yes ☐ No

Background

Please briefly describe why you are seeking therapy._____

_____

_____

_____

Ethnic/racial background:_____ Religious/spiritual background:_____

Involvement in religious activities: ☐ None ☐Some/irregular ☐Active

Education Status (grade level/on leave/not in school): _____

Employment

Employment Status: (full time, part time, student, disabled, not working, homemaker, etc.)

_____

Occupation: _____

List any career/work problems: _____

Social/Family

Marital/relationship status: _____

Sexual orientation: _____

Do you have children? If so, please write names/ages:_____

_____

Does anyone else live at home? ☐ Yes ☐ No If yes, who? _____

Did your parents divorce or separate? ☐ Yes ☐ No If yes, how old were you? _____

If you were physically disciplined as a child, were you ever injured as a result? ☐ Yes ☐ No

Did anyone ever purposefully injure you in other circumstances (that is, when not being disciplined)? ☐ Yes ☐ No

Have you ever had a physical fight with anyone, including your spouse/partner (including throwing things, hitting, shoving, etc)? ☐ Yes ☐No

Have you ever had unwanted sexual contact? ☐ Yes ☐No

Psychiatric/Medical

Are you presently seeing another therapist? ☐ Yes ☐ No

Have you ever been hospitalized or participated in a partial hospital program for mental or emotional difficulties? ☐ Yes ☐No

Are you currently receiving medications for mental or emotional difficulties? ☐ Yes ☐No

Please list all medications you are currently taking. Use back if more space is needed:

Date began	Dosage	Medication	Purpose	With what Results?

Does anyone in your family have a history of any mental health problems? ☐ Yes ☐No

If yes, please list below. Include any suicides. Please use the back for additional space.

Relative Mental Health Diagnosis

Please list *current* medical problems: _____

Please list *past* medical problems: _____

Approximate date of last physical exam by a doctor: _____

What was the outcome? _____

Do you have any problems with your sleep? ☐ Yes ☐No

Are there any sexual issues that cause you concern? ☐ Yes ☐No

Other:

Are you required by a court to have this appointment? ☐ Yes ☐No

If yes, please explain: _____

Are you presently in the midst of a divorce or custody battle? ☐ Yes ☐No

If yes, please explain: _____

Are you presently suing anyone or thinking of suing anyone? ☐ Yes ☐No

If yes, please explain: _____

Have you ever been involved in a lawsuit? ☐ Yes ☐No

If yes, please explain: _____

Have you ever been arrested for a crime? ☐ Yes ☐No

If yes, please explain: _____

What else would be helpful for me to know as we begin our work together? _____

_____

_____

Signature Date