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Client Information Form

Name: _____ Date: _____

Address: _____ Age: _____

_____ Date of birth: _____

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 week that you can forward to your insurance company to request reimbursement? ☐ Yes ☐ No

Please briefly describe why you are seeking therapy._____

_____

_____

_____

_____

Ethnic/racial background: _____

Religious/spiritual background: _____

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

Sexual orientation: _____

Gender Identity/Preferred Pronoun: _____

Education

Years (From – To) School(s) Degree Earned (if applicable)

List any problems with school/adjustment to school: _____

_____

_____

Employment

Employment Status: ☐Full-time ☐Part-time ☐Homemaker ☐Unemployed ☐Retired ☐Disabled ☐Student

Occupation: _____

Have you changed jobs often: _____

Are you satisfied with your current work situation: _____

List any career/work problems: _____

_____

Social/Family

Marital/relationship status: ☐ Single ☐ Married ☐ Cohabitating ☐ Separated ☐ Divorced ☐ Widowed

If married/partnered, how long? _____

Spouse's/partner's occupation: _____

How do you get along with your current spouse/partner: _____

_____

Children (if applicable):

Name	Age	Sex	Living at home?	Adjustment problems

How do you get along with your children? _____

_____

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

What individual(s) in your life (family and or friends) provide you with the greatest source of social support?_____

Please provide the following information about your family:

Relative	Name	Living? (Y/N)	Age (or age at death)	Health status (or cause of death)	Occupation	If living, where does s/he live?
Mother						
Father						
Step-Parent(s)						
Sibling(s)						
Other						

Where were you born? _____

Where did you grow up? _____

Were your parents ever separated? ☐ Yes ☐ No If yes, how old were you? _____

Did your parents get divorced? ☐ Yes ☐ No If yes, how old were you? _____

Did your parents remarry? ☐ Yes ☐ No If yes, how old were you? _____

At what age did you move out of your parents' home? _____

List any other relevant aspects of early development:_____

_____

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

Did you ever have sexual contact with someone that you did not want? ☐ Yes ☐ No

Have you experienced or witnessed any events that felt life threatening? ☐ Yes ☐ No

Have you experienced physical or sexual abuse or assaults? ☐ Yes ☐ No

Psychiatric/Medical

Are you presently seeing another therapist? ☐ Yes ☐ No

If yes, who? _____

Have you previously been in counseling or therapy before (including group, individual, marital/couples, or family counseling)? ☐ Yes ☐ No

Age	Duration of Therapy	Name of Therapist	Reason for Therapy	With what Results?

If you have been in psychotherapy before, was it helpful? ☐ Yes ☐No ☐ Unsure

In what way(s) was it helpful? _____

_____

In what way(s) was it unsatisfactory? _____

_____

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

If yes, when and why?

Year/Date	Age	Length of Hospitalization	Reason for Hospitalization

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

Name of provider: _____

Please list all medications you are currently taking:

Date began	Dosage	Medication	Purpose	With what Results?

Please list any *psychiatric* medication you have taken *in the past*:

Date began	Dosage	Medication	Purpose	With what Results?

How frequently do you drink alcohol? _____days per week

On a day when you do drink alcohol, how many drinks do you have on average (1 drink= 1 bottle of beer, ½ cup of wine, 1 oz of hard alcohol)_____ drinks

How frequently do you take recreational drugs? ☐ never ☐ infrequently ☐ moderately ☐ frequently ☐ daily

Which drugs have you used in the past? _____

_____

_____

How much tobacco do you smoke/chew each day? _____

How much caffeine do you consume each day? _____

Has drinking or drug use ever caused any problems in your work, school, or relationships?

☐ Yes ☐No

If yes, please explain: _____

_____

_____

Have you ever received treatment for drug or alcohol abuse? ☐ Yes ☐No

If yes, please describe the program, dates, and outcome: _____

_____

_____

If you have not received drug/alcohol abuse treatment, has treatment ever been recommended for you? ☐ Yes ☐No

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

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

If yes, list who has been diagnosed with:

Depression _____

Bipolar/Manic-Depression _____

Anxiety _____

OCD _____

Schizophrenia _____

Alcohol/Drug Abuse _____

Suicide _____

Other _____

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 regularly experience physical pain? ☐ Yes ☐No

If yes, please explain: _____

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

If yes, please describe:_____

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

If yes, please describe:_____

Other:

Is your reason for seeking therapy related to an accident or an injury? ☐ Yes ☐No

If yes, please explain: _____

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: _____

Please list/describe any additional stressors that you or close family members have recently experienced: _____

_____

_____

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

_____

_____

_____

Signature Date