CLIENT INFORMATION FORM

DATE: _______________

NAME:____

GENDER: M F DATE OF BIRTH: ______ / ______ / __________

ADDRESS:

____

____

____

MAY WE CORRESPOND BY EMAIL? Yes No IF YES, WHICH DO YOU PREFER? PHONE EMAIL TEXT

EMAIL ADDRESS:

____

HOME PHONE	DAYTIME PHONE	CELL PHONE
Number:	Number:	Number:
Okay to Leave Message? Y N	Okay to Leave Message? Y N	Okay to Leave Message? Y N Okay to text? Y N

MARITAL STATUS: SINGLE MARRIED DIVORCED DOMESTIC PARTNER WIDOWED

PERSON FILLING OUT FORM, IF NOT CLIENT:

____

RELATIONSHIP TO CLIENT:

____

EMERGENCY CONTACT: _________________________________ PHONE: ________________________

Are you involved in any legal proceedings (e.g. Worker's Compensation Claim, child custody dispute, etc) which may involve your therapist? Yes No

If yes, please describe:

____

____

____

How did you hear about me?

____

CLIENT HISTORY, CONCERNS AND GOALS

Please fill in the following information as completely as possible. All information is covered by our confidentiality policy. Use the back of form as necessary.

Describe what has happened recently that led you to seek therapy now.

____

____

____

____

Describe current concerns and symptoms.

____

____

____

____

In each list, circle the one response which best applies:

My current concerns and symptoms are:

a) the continuation of a long-standingcondition
b) a recent worsening of an on-going condition
c) the reoccurrence of a previous condition
d) significantly different from any previous condition
e) my first occurrence of any condition

My current symptoms developed:

a) suddenly (less than four weeks)
b) gradually (one to several months)
c) very gradually (one to several years)

Have you been in psychotherapy or been hospitalized in a psychiatric facility? (Please list names of past therapists and hospitalizations, dates, and reason for treatment.)

____

____

____

____

Describe your current health including diet, exercise, chronic health problems etc.

____

____

____

Please check all of the symptoms you are currently experiencing:

______Depression _________Weight Changes _______Difficulty concentrating

______Panic attacks _________Perfectionism _______Difficulty sleeping

______Body aches/pains _________Nightmares _______Anxious/tense

______Lonely/isolated _________Thoughts of suicide _______Inferiority feelings

______Hearing voices _________Low energy _______Confusion

______Rage _________Feelings of hopelessness _______Obsessions/compulsions

List current involvement with other mental professionals:

____

____

Do you have thoughts about hurting yourself or others? Y N
If yes, please describe:

____

____

____

____

Medical history: Date of last physical exam:________

Name of your health care provider________________________________ Phone: _______________

Please list major injuries, illnesses or surgeries.

Condition

____

Dates ____

Treatment____

____

____

____

____

____

Are you currently on any medication your medical condition (circle one)? Y N

Medication and dosage

____

Prescribing Physician

____

Date Started ____

What, if any, psychiatric medications you have taken in the past (and are not taking currently)?

Medication and dosage:

____

Prescribing Physician

____ Phone: _____________

Date Started _______________________ Date Ended _______________________

Please indicate any significant prenatal events and developmental history.

____

____

____

Please list other substances that you use; include amount and frequency.

Alcohol ____

Heroin ____

Marijuana ____

Psychedelics (e.g. LSD) _______________________________________

Caffeine ____

Methamphetamine ____

Tobacco (e.g. cigarettes) _____________________________________

Other ____

Family and Other Information

List parents, siblings or any other significant members in your household **while growing up**:

____

Name Gender Current Age Relationship to you

____

Name Gender Current Age Relationship to you

____

Name Gender Current Age Relationship to you

____

Name Gender Current Age Relationship to you

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Name Gender Current Age Relationship to you

____

Name Gender Current Age Relationship to you

____

Name Gender Current Age Relationship to you

What was it like for you growing up in your family?

____

____

____

____

List current partner, children and/or others in your household?

____

Name Gender Current Age Relationship to you

____

Name Gender Current Age Relationship to you

____

Name Gender Current Age Relationship to you

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Name Gender Current Age Relationship to you

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Name Gender Current Age Relationship to you

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Name Gender Current Age Relationship to you

____

Name Gender Current Age Relationship to you

What is it like for you in your current living situation?

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____

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____

Circle if appropriate for your partner:

Substance abuse/alcohol: Past Present
Neglect/abuse: Past Present
Violence: Past Present
Sexual abuse/assault: Past Present
Emotional abuse: Past Present
Chronic physical illness: Past Present

Circle if appropriate for your family:

Substance abuse/alcohol: Past Present
Neglect/abuse: Past Present
Violence: Past Present
Sexual abuse/assault: Past Present
Emotional abuse: Past Present
Chronic physical illness: Past Present

Briefly describe your current support system (family, friends, organizations, self).

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____

____

Describe any spiritual or meditative activities that you are involved in:

____

____

____

Education and Employment:

What is the highest level of education you have completed (circle one)?

a) Grade 8 or less
b) Some high school
c) High school graduate
d) Technical school
e) Some college
f) College graduate
g) College beyond bachelor level
h) Graduate school

11) What is your ethno-cultural group (circle one)?

a) African American (Black)
b) American Indian
c) Asian American/Pacific Islander
d) European American (White)
e) Latino (Hispanic)
f) Other: ____________________

Current employment and work history (summary):

____

____

____

____

Have you served in the military (circle one)? Yes No

If yes, which service branch?

____

When did you serve, and for how long? _______________________________________