Client Information Form

A. Personal Information

Today's Date:___________________

Your full name ____

Date of birth ____________________ Age ________ Social Security # ____________________

Address ____ Apt # _________

City ____________________________State ______________ Zip Code ___________________

I may need to send postal mail to clients on occasion. If this is ok, please initial here:_____

To (re)schedule appointments, where may I contact you?

Home/evening phone ______________________ Cell phone __________________________

May I leave you a voicemail message? ☐ Yes ☐ No

May I leave a message with someone at these numbers? ☐ Yes ☐ No

E-mail address ____

***Please note: Email correspondence is not considered a confidential medium of communication**

I may need to send e-mail to clients on occasion. If this is ok, please initial here: _____

Were you referred to my office by someone? ☐ Yes ☐ No

If "Yes", by whom? ____

Please complete the following:

Gender:

☐ Male ☐ Female ☐ Transgender ☐ Other_______________________

Ethnic/Racial Identity:

☐ African-American ☐ Asian/Pacific Islander ☐ Multi-racial ☐ Caucasian

☐ Latina/Latino ☐ Native American ☐ Other:___________________________

Relationship Status:

☐ Single ☐ Committed Relationship ☐ Married ☐ Separated/Divorced

☐ Domestic Partnership ☐ Widowed

Sexual Orientation:

☐ Heterosexual ☐ Gay/Lesbian ☐ Bisexual ☐ Other ☐ Not Sure

☐ Prefer not to say

Emergency Contact Information

Name: ____

Address: ____

Phone: ________________________ Relationship to you:_______________________

Employment

☐ I am currently employed ☐ I am not currently employed

Name of current employer ____

Work phone ___________________________________

How long have you been at your current position? _____________________________________

Education

What is the highest level of education you have obtained?_______________________________

Would you like your therapist to coordinate treatment with your physician? ☐ Yes ☐ No

If "Yes," list physician's name/ phone #____

<u>B. Clinical Information - Overall health and mental health</u>

Have you ever previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐ No

If “Yes”, by whom, when, and for what? ____

____

Have you previously been prescribed psychiatric medications? ☐ Yes ☐ No

If “Yes,” most recent time/date & what were you prescribed?

____

Have you ever been hospitalized for a psychiatric reason? ☐ Yes ☐ No

Have you ever made a suicide attempt/gesture? ☐ Yes ☐ No

If “Yes,” most recent time/date?

____

Please list current or chronic health problems:____

____

Please list current medications (prescribed and OTC):______________________________________

____

Please briefly describe your reason(s) for coming in today:

____

____

____

____

1. How would you rate your current physical health? (please circle)

   Poor Unsatisfactory Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very Good

Please list any sleep problems you are currently experiencing:

____

3. On average, how many times per week to you exercise?________________________

4. Please list any difficulties you experience with your appetite or eating patterns.

____

5. Are you currently experiencing overwhelming sadness, grief or depression?

☐ Yes ☐ No If “Yes,” for how long?____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?

☐ Yes ☐ No If “Yes,” when did this start?_______________________________________

7. How many alcoholic drinks do you consume in a week?____________________________

Is this a concern for you or anyone in your life?_______________________________________

8. How often do you engage in recreational drug use? (please circle one)

Daily Weekly Monthly Infrequently Never

Is this a concern for you or anyone in your life?_______________________________________

9. Are you currently in a romantic relationship?

☐ Yes ☐ No If “Yes,” for how long?____

On a scale of 1 (low)-10 (high), how do you rate your relationship?________________________

10. What significant life changes or stressful events have you experienced recently?

____

____

FAMILY MENTAL HEALTH HISTORY

Please indicate if there is a history of any of the following for you or anyone in your family. If yes, please indicate the family member's relationship to you in the space provided.

ADD/ADHD	yes/no	________________
Alcohol/Substance Abuse	yes/no	________________
Anxiety	yes/no	________________
Depression	yes/no	________________
Domestic Violence	yes/no	________________
Eating Disorders	yes/no	________________
Obesity	yes/no	________________
Obsessive Behaviors	yes/no	________________
Schizophrenia	yes/no	________________
Physical/Sexual Abuse	yes/no	________________
Suicide Attempts	yes/no	________________

ADDITIONAL INFORMATION

1. Are you currently employed? If yes, what is your current employment situation?

____

Do you enjoy your work? Is there anything stressful about your current work?

____

____

2. Do you consider yourself to spiritual or religious? If yes, please describe:

____

____

3. What do you consider to be your strengths?

____

____

4. What do you consider to be some of your weaknesses?

____

____

5. What are your goals for therapy?

____

____

____

______________________________ ____________
Client’s Signature **Date**

Thank you for completing this form.
Data is used solely for the purpose of understanding treatment concerns and is confidential.