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CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

Your name: _____
Last **First** **Middle Initial**

Age _____ **Date of birth:** _____ Gender Identity: _____

Home street address: _____

City: _____ **State:** _____**Zip:**_____

Name of Employer:_____

Address of Employer: _____

City: _____ **State:** _____**Zip:**_____

Cell Phone: _____ **Email:** _____
Secondary Phone: _____ **Phone type (work/land)** _____

Calls will be discreet, but please indicate any restrictions or preferences for leaving messages:_____

Referred by: _____

- May I have your permission to thank this person for the referral?
  ☐ **Yes** ☐ **No**
- If referred by another clinician, would you like for us to communicate with one another?
  ☐ **Yes** ☐ **No**

Person(s) to notify in case of any emergency: _____
Name **Phone**

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Please briefly describe your presenting concern(s): _____
_____
_____
_____

What are your goals for therapy? _____
_____
_____
_____

Preferred Pronouns (circle all that apply): He She They Other _____

The following information on this form will help guide your treatment.

Please try to fill out as much as you are comfortable disclosing.*

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses: _____

_____

_____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Do you smoke or use tobacco? YES NO If YES, how much per day?_____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? ____

Do you use any non-prescription drugs? YES NO

If YES, what kinds and how often? _____

Have any of your friends or family members voiced concern about your substance use? YES NO

Have you ever been in trouble or in risky situations because of your substance use? YES NO

Previous medical hospitalizations (Approximate dates and reasons):_____

_____

_____

Previous psychiatric hospitalizations (Approximate dates and reasons):_____

_____

_____

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
(Please list approximate dates and reasons): _____

_____

_____

Height _____ Weight (if applicable) _____ Age_____

Please describe your gender and sexual identities:
(e.g., Lesbian/Gay/Bisexual/Asexual/Fluid/Quesioning/Transgender/Male/Female/Nonbinary):

_____

_____

Please describe your Ethnic Identity:
(e.g., African/African-American/Black/Latino/Latino-American/Bi-Racial/Multi-Racial (describe)/American Indian/Alaska Native/Middle Eastern/Middle Eastern-American/Asian/Asian-American/Asian Pacific Islander/White/European-American, etc.

_____

_____

FAMILY:

Who raised you? _____

How would you describe your relationship with your mother(s) (if relevant)?_____

_____

How would you describe your relationship with your father(s)? (if relevant)?_____

_____

Were there any other primary caregivers who you had a significant relationship with? If so, please describe how this person may have impacted your life: _____

_____

Describe the structure of your family growing up (parents married, parents divorced (your age), raised by grandparents, raised by two mothers/fathers, etc.)

_____

If there was a major change in your family growing up (divorce, death of parent), how old were you and how did this impact you? _____

_____

_____

How many sisters do you have? _____ Ages? _____

How many brothers do you have? _____ Ages? _____

How would you describe your relationships with your siblings? _____

_____

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ____ How Long? ____ Relationship Satisfaction: POOR 1 2 3 4 5 6 7 EXCELLENT

Married/Life Partnered? _____ How Long? ____ Previously Married/Life Partnered? YES NO

If so, length of previous marriages/committed partnerships_____

Do you have Children?____ If YES, how many and what are their ages:_____

Describe any problems any of your children are having: _____

_____

List the names and ages of those living in your household: _____

_____

Please briefly describe any history of abuse, neglect and/or trauma: _____

_____

_____

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Please briefly describe your coping mechanisms and self-care:_____

_____

_____

Is spirituality important in your life and if so please explain:_____

_____

Briefly describe your diet and exercise patterns:_____

_____

EDUCATION & CAREER

High School/GED___ College Degree___ Graduate Degree(or Higher)___ Vocational Degree___

What is your current employment?_____

POOR EXCELLENT
Employment Satisfaction: 1 2 3 4 5 6 7

Any past career positions that you feel are relevant?_____
_____

What do you think are your strengths?_____
_____
_____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
Anxiety →				People in General →				Serious Illness →		
Depression				Parents				Nausea/Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/Partnership				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Employer/Co-Worker(s)				Shortness of Breath		
Irritability				Finances				Chest Pain		
Concentration				Legal Problems				Lump in the Throat		
Headaches				Sexual Concerns				Sweating		
Loss of Memory				History of Sexual Assault				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in joints		
Trusting Others				Violence in Relationship				Allergies		
Communicating with Others				Thoughts of Hurting Someone Else				Often Make Careless Mistakes		
Drugs				Hurting Self				Fidget Frequently		
Alcohol				Thoughts of Suicide				Speak Without Thinking		
Caffeine				Sleeping Too Much				Waiting Your Turn		
Frequent Vomiting				Sleeping Too Little				Completing Tasks		
Eating Problems				Getting to Sleep				Paying Attention		
Severe Weight Gain				Waking Too Early				Easily Distracted by Noises		
Severe Weight Loss				Nightmares				Hyperactivity		
Blackouts				Head Injury				Chills or Hot Flashes		

FAMILY HISTORY OF (Check all that apply):

Drug/Alcohol Problems			Physical Abuse			Depression		
Legal Trouble			Sexual Abuse			Anxiety		
Domestic Violence			Hyperactivity			Psychiatric Hospitalization		
Suicide			Learning Disabilities			"Nervous Breakdown"		

Any additional information you would like to include:

_____

_____