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CLIENT INFORMATION FORM

This Form is Confidential

Today's date: _____

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

Date of birth: _____ **Social Security #:** (last four) _____

Home street address: _____

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

Name of Employer: _____

Address of Employer: _____

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

Home Phone: _____ **Work Phone:** _____

Cell Phone: _____ **Email:** _____

Calls will be discreet, but please indicate any restrictions: _____

Do you consent to the following types of messages being left regarding appointment (circle all agree to) Voice Mail Text Messages E-Mail

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**

Address _____ **Relation to you** _____

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): _____

Signature of Person responsible for payment (must be signed for services to begin)

_____

Your Current Treatment Team's Information: Please list your treating physicians below, if applicable, and let me know if you would like me to communicate with these health care professionals regarding our work together. You will need to complete a separate consent to release information.

Physician: _____ Phone number: _____

Physician: _____ Phone number: _____

Medications: Please list medication names, dosages if known and how often you take them.

_____
_____
_____
_____

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

What are your goals for therapy? _____
_____
_____
_____
_____

How long do you expect to be in therapy in order to accomplish these goals (or at least feel like you have the tools to accomplish them on your own)? _____

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_____ Gender _____

Sexual & Gender Identity: __ Heterosexual __Lesbian __Gay __Bisexual __Transgender
__ Asexual __ In Question __Other

Racial/Ethnic Identity:
__African/African-American/Black __ Latino/Latino-American __Bi-Racial/Multi-Racial
__American Indian/Alaska Native __ Middle Eastern/Middle Eastern-American
__Asian/Asian-American/Asian Pacific Islander __White/European-American __Not listed

FAMILY:

How would you describe your relationship with your mother?_____

How would you describe your relationship with your father?_____

Are your parents still married?_____ If they divorced, how old were you when they separated or divorced, and how did this impact you? _____

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

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?_____

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

Any past career positions that you feel are relevant?_____

What do you think are your strengths?_____