



Client Information Form

Today's date: _____

Date of birth: _____

Your name: _____
Last First Middle Initial

Home street address: _____

City: _____ State: _____ Zip: _____

Place of
Employment: _____

Occupation: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

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

Referred by: _____

- May I have your permission to thank this person for the referral?
- If referred by another clinician, would you like for us to communicate with one another?

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

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

Please briefly describe your current 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)? _____

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? (Please remember that this form is completely confidential).
 YES NO If YES, what kinds and how often? _____

Previous 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): _____

FAMILY:

How would you describe your relationship with your mother? _____

How would you describe your relationship with your father? _____

Are you parent's still married or did they divorce? _____ 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? _____

RELATIONSHIP STATUS:

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

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 →				Nausea →		
Depression				Parents				Abdominal Distress		
Mood Changes				Children				Fainting		
Anger or Temper				Marriage/Partnership				Dizziness		
Panic				Friend(s)				Diarrhea		
Fears				Co-Worker(s)				Shortness of Breath		
Irritability				Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches				Legal Problems				Sweating		
Loss of Memory				Sexual Problems				Heart Palpitations		
Excessive Worry				History of Child Abuse				Muscle Tension		
Feeling Manic				History of Sexual Abuse				Pain in joints		
Trusting Others				Domestic Violence				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:
