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Client Information Form

Today's date: _____

Please provide the following information for my records. Leave blank any questions you would rather not answer. Information you provide here is held to the same standards of confidentiality as our therapy.

Your name: _____ Date of Birth: _____ Age: _____

Sex: _____ Gender: _____ Personal pronoun you use to identify yourself: _____

Marital Status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Other

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ May I leave a message? _____

Cell/other phone: _____ May I leave a message? _____

Email: _____ May I email you? _____

*Please be aware that email might not be confidential

Emergency Contact Information

Name: _____ Phone: _____

Address: _____

Relationship to you: _____

Insurance Claim Information

Insured's Name: _____ Date of Birth: _____ Sex: _____

Insured's Address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Client relationship to Insured: _____

Insured's I.D. Number: _____ Policy Group or FECA #: _____

Employer's or School Name: _____ Insurance Plan Name: _____

Referred by: _____

Your medical care (From whom or where do you get your medical care?)

Clinic name: _____ Phone: _____

Doctor's name: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ☐ Yes ☐ No

Your current employer

Employer:_____Occupation: _____

Length of time with this employer:_____ Are you happy at your current position?_____

Present relationships

How long have you been together with your partner/spouse? _____

_____

On a scale of 1-10, how would you rate the quality of your current relationship? _____

Do you have children? _____ How do you get along with your children? _____

Past Psychological/Psychiatric Treatment

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services? Please include both inpatient and outpatient treatment. ☐ No ☐ Yes

If yes, please indicate:

When	From Whom	For What	Results

Have you ever taken medications for psychiatric or emotional problems? ☐ No ☐ Yes

If yes, please indicate:

When	From Whom	Medication	For What	Results

Health Information

How is your physical health at present? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.): _____

Are you having any problems with your sleep habits? ☐ No ☐ Yes

If yes, check where applicable:

☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Sleeping too much ☐ Poor quality sleep

☐ Disturbing dreams ☐ Other_____

Are you having any difficulty with appetite or eating habits? ☐ No ☐ Yes

If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting

Have you experienced significant weight change in the last 2 months? ☐ No ☐ Yes

Do you regularly use alcohol? ☐ No ☐ Yes
In a typical month, how often do you have 4 or more drinks in a 24-hour period?_____

How often do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely Never

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (circle any that apply and list family member, e.g., Sibling, Parent, Uncle, etc.):

Difficulty	**Family Member**
Depression	
Bipolar Disorder	
Anxiety Disorders	
Panic Attacks	
Schizophrenia	
Alcohol/Substance Abuse	
Eating Disorders	
Learning Disabilities	
Trauma	
History Suicide Attempts	

List of Symptoms

Please circle any of the following that have been bothering you lately.

inferiority feelings	children	loneliness	headaches	phobias
nervousness	shyness	education	insomnia	extreme fatigue
suicidal thoughts	separation	guilt	agoraphobia	panic attacks
making decisions	drug use/abuse	bowel trouble	appetite	overweight
health problems	anger	depression	fears	sexual abuse
stomach trouble	sleep	divorce	finances	abused as a child
career choices	relaxation	alcohol use	confidence	short temper
concentration	painful thoughts	compulsions	unhappiness	work
being a parent	energy (hi or low)	self-control	stress	memory
marriage	legal matters	ambition	relationship troubles	my thoughts
nightmares	friends	spacing out	tiredness	sadness
obsessive thinking	compulsivity	perfectionism	self-esteem	homicidal
sexual problems	fetishes	conflict	anxiety	eating problems
no interests	impotence	sexual orientation		

What do you consider to be your strengths? _____
_____

What do you like most about yourself? _____
_____

What are effective coping strategies that you've learned? _____
_____

What are your goals for therapy? _____