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CLIENT INFORMATION FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Client Name:_____
(First) (Last)
Name of parent/guardian (if client is under 18 years): _____
(First) (Last)
Client DOB:_____/_____/_____ Age: _____ Gender: _____

Marital Status: ❑ Never Married ❑ Domestic Partner ❑ Married ❑Separated ❑Divorced ❑ Widowed

Please list all children's names and ages: _____

_____

Address: _____ City, State, Zip _____

Telephone: (Cell)_____ (Alt. Number) _____

Email: _____

Where may I leave a message? ❑ Home ❑ Work ❑ Cell ☐ Email
** Please note: Email and text correspondence are not considered to be confidential mediums of communication.*

Who referred you or how did you find out about this service? _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

❑ No ❑ Yes, previous therapist/practitioner/facility: _____

Please list year(s) when you received services and length of time:_____

Did you value the therapeutic service you received? ❑Yes ☐No

Have you ever attempted suicide? ❑Yes ❑No

If yes, number of times attempted _____ Dates _____

Method(s) used _____

Are you suffering from any suicidal ideation at present? ❑Yes ❑No

Are you currently taking any prescription medications? ☐ No ❑ Yes, please list medication and prescribing

doctor: _____

Have you ever been prescribed psychiatric medication? ❑ No ❑ Yes, please list and provide dates:

_____

General Health and Mental Health Information

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

Poor Satisfactory Good Very Good

Please list any specific health problems you are currently experiencing:

_____

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

Poor Satisfactory Good Very Good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

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

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression? ❑ No ❑ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? ❑ No ❑ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? ❑ No ❑ Yes

If yes, please describe: _____

8. Do you drink alcohol? ❑Never ❑Socially ❑Moderately ❑Often

9. Do you drink caffeine (sodas, tea or coffee)? ❑Never ❑Socially ❑Moderately ❑Often

10. Do you smoke? ❑Never ❑Socially ❑Moderately ❑Often

11. How often do you engage in recreational drug use? ❑Never ❑Socially ❑Moderately ❑Often

12. Are you concerned about any other behavior possibly being/becoming a problem in your life?

❑ No ❑ Yes, please list the behaviors _____

11. Are you currently in a romantic relationship? ❑ No ❑ Yes If yes, for how long? _____

Rate your relationship on a scale of 1-10 _____ (10 is most satisfying)

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

_____

_____

_____

Family Mental Health History:

In the section below identify if there is a family history of any of the following. If yes, please indicate yourself or the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

	Please Circle	List Family Member(s)
Addictions (*non-alcohol or drug related)* gambling, porn, love/relationship, shopping, TV, video games, work, etc.	Yes / No	
ADHD	Yes / No	
Affair	Yes / No	
Alcohol/Substance Abuse	Yes / No	
Anxiety	Yes / No	
Bipolar	Yes / No	
Borderline Personality Disorder	Yes / No	
Depression	Yes / No	
Domestic Violence	Yes / No	
Eating Disorders	Yes / No	
Learning Differences	Yes / No	
Narcissism	Yes / No	
Obesity	Yes / No	
Obsessive Compulsive Behavior	Yes / No	
PTSD	Yes / No	
Physical Abuse	Yes / No	
Schizophrenia	Yes / No	
Sexual Abuse Perpetrator	Yes / No	
Sexual Abuse Victim	Yes / No	
Suicide Attempts	Yes / No	
Other		

Additional Information:

1. Are you currently employed? ☐ No ☐ Yes

   If yes, what is your current employment situation? _____
   If no, how long have you been unemployed? _____
   Do you enjoy your work? ☐ No ☐ Yes Is there anything stressful about your current work?_____
   _____

2. Do you consider yourself to be spiritual or religious? ☐ No ☐ Yes If yes, describe your faith or belief:

   _____

   _____

3. What do you consider to be some of your strengths? _____
   _____
   _____

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

5. To whom are you currently going for emotional support? _____
   _____

6. Is there anything else you can think of that will be helpful for me to know about you? _____
   _____
   _____

7. What are some of your goals for coming to therapy? In other words, what will be different in your life as a result of therapy and how will we observe or measure it?
   For example: *I will fall asleep easily and remain asleep for at least 6 contiguous hours. I will be in a healthy, loving and intimate relationship. I will have more confidence in myself and I will be able to say "no" when I mean "no" and "yes" when I mean "yes". I will remain calm and centered when I encounter my ex.*
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____
   _____