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Client Information Form

Name: _____ Date: _____

Address: _____ Age: _____

_____ Date of birth: _____

Phone: hm _____ → ok to leave message? ❑ yes ❑ no
wk _____ → ok to leave message? ❑ yes ❑ no
cell _____ → ok to leave message? ❑ yes ❑ no
other _____ → ok to leave message? ❑ yes ❑ no
email _____ → ok to email you? ❑ yes ❑ no

Emergency contact

Name: _____ Relationship to you: _____

Phone: hm: _____ wk: _____ cell: _____

Address: _____

Referral Information

How did you hear about my services? _____

May I have your permission to thank this person for the referral? ❑ yes ❑ no

Reimbursement

Would you would statements provided to you each week that you can forward to your insurance company to request reimbursement? ❑ yes ❑ no

Please describe briefly why you are seeking therapy. _____

_____

_____

_____

_____

_____

_____

_____

Ethnic/racial background: _____

Religious/spiritual background: _____

Involvement in religious activities: ❑ none ❑ some/irregular ❑ active

Education / Work

Education and Training

Dates		Schools	Area(s) of study? Special classes?	Date of graduation	Degree earned, If applicable
From	To				

List any problems with school / adjustment to school: _____

_____

_____

_____

Employment

Employment status: ❑ full-time ❑ part-time ❑ homemaker ❑ unemployed ❑ retired ❑ disabled ❑ student

Occupation: _____

Annual Household income (circle one):

❑ less than $39,999 ❑ $49,000–$69,999 ❑ $70,000–$99,999 ❑ $100,000–$149,999 ❑ $150,000-199,000 ❑ 200,000 +

Dates		Name of employer	Job Title / Duties	Reason for leaving
From	To			

List any career/work problems: _____

_____

_____

_____

Social / Family

Marital/relationship status: ❑ single ❑ married ❑ cohabitating ❑ separated ❑ divorced ❑ widowed

If married/partnered, how long? _____

Spouse's/partner's occupation _____

Marital/Relationship History

	Spouse's/Partner's name	Your age at marriage	Spouse's age at marriage	Your age when divorced/widowed
First				
Second				
Third				

How do you get along with your current spouse or partner? _____

_____

_____

_____

Children

Name	Age	Sex	Living at home?	Adjustment problems?

How do you get along with your children? _____

_____

_____

Does anyone else live at home? ❑ yes ❑ no If yes, who? _____

_____

What individual(s) in your life (family and or friends) provide you with the greatest source of social support? _____

_____

_____

Please provide the following information about your family:

Relative	Name	Living? (Y/N)	Age *(or age at death)*	Health Status *(or cause of death)*	Occupation	If living, where does s/he live?
Mother						
Father						
Stepparent(s)						
Siblings						
Other						

Where were you born? _____

Where did you grow up? _____

Describe your parents' relationship with each other: _____

_____

_____

Were your parents ever separated? ❑ yes ❑ no If yes, when? _____

Did your parents get divorced? ❑ yes ❑ no If yes, when? _____

Did your parents remarry? ❑ yes ❑ no If yes, when? _____

Describe your relationships with your parents: _____

_____

_____

Describe your relationships with your brothers/sisters (past & present): _____

_____

_____

At what age did you move out of your parents' home? _____

List any other relevant aspects of early development: _____

_____

If you were physically disciplined as a child, were you ever injured as a result? ❑ yes ❑ no

Did anyone ever purposefully injure you in other circumstances (that is, when not being disciplined)? ❑ yes ❑ no

Did you ever have sexual contact with someone that you did not want? ❑ yes ❑ no

Have you experienced or witnessed any traumas (events that felt life threatening)? ❑ yes ❑ no

Have you experienced physical or sexual abuse or assaults? ❑ yes ❑ no

Psychiatric / Medical

Are you presently seeing another therapist? ❑ yes ❑ no If yes, who?_____

Have you previously been in counseling or therapy before (including individual, group, marital/family)? ❑ yes ❑ no

Age	Duration of Therapy	Name of Therapist	Reason for therapy	With what results?

If you have been in psychotherapy before, was it helpful? ❑ yes ❑ no ❑ unsure

In what way(s) was it helpful? _____

_____

In what way(s) was it unsatisfactory? _____

_____

Have you ever been hospitalized or participated in a partial hospital program for mental or emotional difficulties? ❑ yes ❑ no

If yes, when and why?

Dates	Age	Where hospitalized?	Reason for hospitalization

If you have not been hospitalized, has hospitalization for mental or emotional difficulties ever been recommended for you? ❑ yes ❑ no

If yes, when and why? _____

Are you currently receiving medications for mental or emotional difficulties? ❑ yes ❑ no

Name of provider: _____

Please list all medications you are *currently* taking.

Date began	Medication	Dosage	Purpose	With what results?

Please list any *psychiatric* medications you have taken *in the past:*

Age	Duration of Treatment	Name of Physician	Which medications?	Purpose of medications	With what results?

How frequently do you drink alcohol? ❑ never ❑ infrequently ❑ moderately ❑ frequently ❑ daily

How much alcohol do you drink on average? _____ drinks per _____

How frequently do you take recreational drugs? ❑ never ❑ infrequently ❑ moderately ❑ frequently ❑ daily

Which drugs have you used in the past? _____

_____

_____

How much tobacco do you smoke/chew each day? _____

How much caffeine do you consume each day? _____

Has drinking or drug use ever caused any problems in your work, school, or relationships? ❑ yes ❑ no

If yes, please explain: _____

_____

Have you ever received treatment for drug or alcohol abuse? ❑ yes ❑ no

If yes, please describe the program, dates, and outcome: _____

_____

_____

If you have not received drug/alcohol abuse treatment, has treatment ever been recommended for you? ❑ yes ❑ no

If yes, please explain: _____

_____

_____

Have you ever had a physical fight with anyone, including your spouse/partner (including throwing things, hitting, shoving, etc)? ❑ yes ❑ no

Does anyone in your family have a history of any mental health problems? ❑ yes ❑ no If yes, who?

Depression _____

Bipolar/Manic-Depression _____

Anxiety (specify) _____

OCD _____

Schizophrenia _____

Alcohol/Drug Abuse _____

Suicide _____

Other _____

Please list *current* medical problems: _____

_____

_____

Please list *past* medical problems: _____

_____

_____

Past surgeries: _____

_____

Date of last physical exam by a doctor: _____

What was the outcome? _____

Allergies: _____

Do you regularly experience physical pain? ❑ yes ❑ no If yes, please explain: _____

_____

Do you have any problems with your sleep? ❑ yes ❑ no If yes, please describe: _____

_____

_____

Are there any sexual issues that cause you concern? ❑ yes ❑ no If yes, please describe: _____

_____

_____

Other

Is your reason for seeking therapy related to an accident or an injury? ❑ yes ❑ no
If yes, please explain: _____

Are you required by a court to have this appointment? ❑ yes ❑ no
If yes, please explain: _____

Are you presently in the midst of a divorce or custody battle? ❑ yes ❑ no
If yes, please explain: _____

Are you presently suing anyone or thinking of suing anyone? ❑ yes ❑ no
If yes, please explain: _____

Have you ever been involved in a lawsuit? ❑ yes ❑ no
If yes, please explain: _____

Have you ever been arrested for a crime? ❑ yes ❑ no
If yes, please explain: _____

Please list/describe any additional stressors that you or close family members have recently experienced:

_____

_____

_____

Strengths

What are your personal strengths? _____

_____

_____

_____

What are you most proud of in your life? _____

_____

Please list any hobbies/activities: _____

_____

What else would be helpful for me to know as we begin our work together? _____

_____

_____

_____

_____

_____ _____

Signature Date