Client Information Form

This Form is Completely Confidential

Click on Lines to Type

Today's date: _____

Your name: _____

First Middle Initial Last

Preferred name_____**Age & Birthdate**_____**Sexual & Gender Identify**_____

Home street address: _____

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

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? YES NO

If referred by another clinician, would you like for us to communicate with one another? YES NO

Emergency Contact (name, number, relationship to you) _____

I will only contact this person if I believe it is a life or death emergency.

Please type your name here to indicate that I may do so _____

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)?

_____

_____

_____

MEDICAL HISTORY

Please list any significant medical problems, symptoms, or illnesses

_____

_____

Current medication (name, purpose, and indicate if prescribing doctor is GP/psychiatrist/other)

Do you smoke or use tobacco? YES NO How much per day? _____

Do you consume caffeine? YES NO How much per day? _____

Do you drink alcohol? YES NO How much per day/week/month/year? _____

Do you use any non-prescription drugs? Y N How much per day/week/month/year? _____

Previous medical or psychiatric hospitalizations?

Approximate dates and reasons

_____

_____

Have you ever talked with a psychiatrist or other mental health professional? YES NO

FAMILY

Tell me about your parents/primary caregivers.

_____Relationship Satisfaction (0-5, 5 is excellent) 0 (Click 0 to change)

_____Relationship Satisfaction (0-5, 5 is excellent) 0

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_____Relationship Satisfaction (0-5, 5 is excellent) 0

Tell me about your siblings/other children significant in your childhood. Check the box if deceased.

_____Relationship Satisfaction (0-5, 5 is excellent) 0 (Click 0 to change)

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RELATIONSHIPS

Are you currently married or partnered in a committed relationship? YES NO

Relationship Satisfaction (0-5, 5 is excellent) 0 (Click 0 to change)

Describe any previous significant relationships

_____

Do you have children, and if yes, what are their ages? _____

Are any of them having difficulties? YES NO

Are any of them deceased? YES NO

Do you have friends you feel close to and supported by? YES NO

Relationship Satisfaction (0-5, 5 is excellent) 0

Experience or difficulty with any of the following (check all that apply and CIRCLE the main challenges)

	Now	Past			Now	Past			Now	Past
Anxiety				Social gatherings				Nausea		
Depression				People generally				Abdominal Pain		
Mood / Irritability				Parents				IBS / IBD		
Anger / Temper				Children				Dizziness		
Panic				Marriage/Partner				Diarrhea / Constipation		
Fear / Worry				Friends				Shortness of Breath		
Trust				CoWorkers				Chest Pain		
Communication				Employer				Headaches		
Chills/hot flashes				Finances				Sweating		
Lump in throat				Legal Problems				Heart Palpitations		
Memory Loss				Sexual Problems				Muscle Tension		
Allergies				Domestic Violence				Joint pain		
Drugs				Thoughts of hurting others				Sensory Sensitive: sound, smell, light, etc.		
Alcohol				Self-harm				Careless errors		
Caffeine				Suicidal Thoughts				Speak w/o thinking		
Frequent vomiting				Sleep too much				Waiting your turn		
Eating problems				Sleep too little				Start/Complete tasks		
Weight gain				Falling/staying asleep				Too little/much energy		
Weight loss				Nightmares				Too little/much focus		
Blackouts				Head Injury				Too little/much emotion		
FAMILY HISTORY / EARLY CHILDHOOD (check all that apply)										
Drug/Alcohol				Physical Abuse				Depression		
Legal trouble				Sexual Abuse				Anxiety		
Domestic Violence				ADHD/Autism				Psychiatric Hospital		
Suicide				Learning Disability				“Nervous Breakdown”		

Any additional information you would like to include?