

## **CLIENT INFORMATION FORM**

\*This Form is Confidential\*

Today's date:	Date of birth:					
Your name:	First	Middle Initia				
Home street address:						
	State:					
Name of Employer:						
Address of Employer:						
City:	State: 2	Zip:				
Cell Phone:	Work Phone:					
Home Phone:	E-mail:					
Calls will be discreet, but please in	ndicate any restrictions:					
Yes No  - If referred by another clinicity Yes No  Person(s) to notify in case of any  I will only contact this person if	to thank this person for the referral?  an, would you like for us to communic  remergency:  Name  T believe it is a life or death emergence  so: (Your Signature):	Phone cy. Please provide your				
·	, G					
Please briefly describe your prese	enting concern(s):					
What are your goals for therapy?						
How long do you expect to be in like you have the tools to accomp	therapy in order to accomplish the	ese goals (or at least feel				

## \*\*The following information on this form will help guide your treatment. Please try to fill out as much as you are comfortable disclosing.\*\*

## **MEDICAL HISTORY:**

Please explain any significa	ant medical prob	olems, symptoms, or i	llnesses:		
Current Medications: Name of Medication	Dosage	Purpose	Name of Prescribing Doctor		
Do you smoke or use toba	cco? YES NO	If YES, how muc	ch per day?		
Do you drink alcohol?	YES NO	If YES, how muc	ch per day/week/month/year?		
Do you use any non-presc	ription drugs? \				
If YES, what kinds and ho	_				
Have any of your friends of	or family membe	ers voiced concern ab	out your substance use? YES NO		
Have you ever been in tro					
•	•		asons):		
Have you ever talked with (Please list approximate da			ntal health professional? YES NO		
Age: Gende	r:				
Sexual & Gender Identity:			GayBisexualTransgender		
American Indian/Alask	can/Black1 a Native1	Latino/Latino-Ameri Middle Eastern/Midd	Other: canBi-Racial/Multi-Racial lle Eastern-American /European-AmericanNot listed		
FAMILY:					
	our relationship	with your mother?_			
How would you describe y	our relationship	with your father?			

Are your parents still married? If they divorced, how old were you when they separated or divorced, and how did this impact you?
How many sisters do you have? Ages? How many brothers do you have? Ages? How would you describe your relationships with your siblings?
RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:
Currently in Relationship? How Long? Relationship Satisfaction: 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:
List the names and ages of those living in your household:
Please briefly describe any history of abuse, neglect and/or trauma:
Current level of satisfaction with your friends and social support:  1 2 3 4 5 6 7  Please briefly describe your coping mechanisms and self-care:
Is spirituality important in your life and if so please explain:
Briefly describe your diet and exercise patterns:
EDUCATION & CAREER
High School/GED College Degree Graduate Degree(or Higher) Vocational Degree
What is your current employment?
Employment Satisfaction: 1 2 3 4 5 6 7
What do you think are your strengths?

## PLEASE CHECK ALL THAT APPLY:

DIFFICULTY WITH:	NOW	PAST	$\prod$	DIFFICULTY WITH:	NOW	PAST		DIFFICULTY WITH:	NOW	PAST
			$\parallel$				$\perp$			
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			Ш	Employer				Chest Pain		
Concentration				Finances				Lump in the Throat		
Headaches			П	Legal Problems				Sweating		
Loss of Memory				Sexual Concerns				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			$\prod$	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: