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CLIENT INFORMATION

Please take the time to fill out this confidential client information form prior to your first session. This information will help me get to know you and facilitate the beginning of your therapy.

Client_______________________________________ Date of Birth:___/___/___ *Current Age________

Address: ___________________________________ City:________________ State: ____ Zip: ___________

Cell Phone: (____) ___________ Home Phone: (____) ____________ Work Phone (____)_______________

Sex: ☐ Male ☐ Female Subscriber S.S.# (if using insurance): ______-______-______

Employer/School Job Title/Grade

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Partner's Name____________________

Emergency Contact:____________________________________ Telephone:(____) ________________________

Referred by: _______________________________

Sign here for permission to send thanks if a professional referred you: ________________________________

Relevant medical conditions (history, current condition, changes in condition):

____

____

Medications (dosage, dates of initial prescriptions, name of prescribing professional):

____

____

Allergies/adverse reactions to treatment: :____

Primary Care Physician Name: ____________________________________ Telephone ____________________

Address:____

Date of last medical/physical exam____

Reason for seeking therapy____

____

TreatmentGoals____

____

Past therapy or psychiatric treatment____

What, if anything, was helpful? :____

____

Psychiatric hospitalizations (Dates and Locations):_______________________________________

Family History of therapy, psychological, or psychiatric treatment: ______________________________

____

Do you drink coffee? Y or N (#_____cups/daily) Do you smoke Cigarettes? Y or N (#_____per day)

Alcohol? Y or N (#______drinks weekly) Date last drank______ Family History of Alcoholism? Y or N

Recreational Drug Use (Marijuana, Cocaine, Methamphetamine, etc.)? Y or N

Police / Probation involvement (past or present) Y or N Date__________ Please explain ______________

____

Family Structure (who lives in your household? Please provide names, ages and relationship to each)

____

____

Please circle if you have experienced any of the following (past or present):

Mood Changes	Worry/Fear	Panic Attacks	Poor Concentration
Tearfulness	Fatigue	Feeling Hopeless/Helpless	Sleep Problems
Body Image Problems	Sexual Problems	Losses	Phobias
Learning Problems	Spending Sprees	Outbursts of Anger	Lying
Seizures	Head Injury	Gambling Problems	Computer Addiction
Sexual Abuse	Domestic Violence	Traumas	Physical Abuse
Suicide Attempts	Suicidal Ideation	Auditory Hallucinations	Visual Hallucinations

Any other information you believe may be significant_______________________________________

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