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CLIENT INFORMATION FORM **Today's Date** ____________________________

Client Name: ____/______________________________
First Last Name you like to be called

Client Address: ____
Street City State Zip

Phone: Home____ Cell: ____

E-mail: ____ Best way to leave message: □Home □Cell □E-mail

Birthdate: __________________ Age: ________ Gender: □Male □Female □Self-describe ____________________________

Ethnicity: □Caucasian/White □African-American □Asian □Hispanic/Latino/a □Self-describe______________________

Relationship Status □Married □Serious relationship □Divorced □Separated □Single □Widowed

If you are in a romantic relationship, is it: □Generally positive □Neutral □Problematic

Sexual Orientation: □Lesbian □Gay □Straight (heterosexual) □Bisexual □Self-describe___________________________

Children? □No □Yes, ages ____________ Occupation & Employer: ____

Student? □No □Yes, school name____

Education: ____
(highest level of education, degree, major/specialization)

How did you first find out about my services?____

Will you be getting insurance reimbursement? □No □Yes

Current Concerns

Please provide a brief description of the major concerns that led you to seek therapy at this time (continue on back if necessary):____

____

____

____

How long have you been having these difficulties? ____

Describe any major life changes that have recently occurred: ____

____

____

Previous Psychotherapy or Counseling

Name of therapist Address/phone number Treatment dates

____

____

Describe the problem(s) for which you sought therapy: ____

____

What did you like/not like about your previous therapy? Was it helpful? ____

____

Have you been hospitalized for psychiatric or substance abuse problems? □No □Yes, (#) _____times, year(s) _____

Physical Health Status

Do you have any existing medical problems or any current physical symptoms of concern to you? If so, please describe.

____

____

Please list any medications you are currently taking both prescribed and over-the-counter (continue on back if necessary):

Medication/Purpose	Average dosage	Frequency
____	____________	________________
____	____________	________________
____	____________	________________
____	____________	________________

Please indicate any major illnesses, accidents, and/or hospitalizations within the last 5 years:________________________

____

Do you smoke? □No □Yes, (#) ______ per day Do you drink alcohol? □No □Yes, (# drinks)______ per week
Do you drink caffeine? □No □Yes, (# cups) _______ per day
Do you engage in any other substance/drug use? □No □Yes, explain ____
Do you engage in (circle all that apply) a spiritual/religious practice, yoga, or meditation?
□Regularly □Occasionally □Rarely □Never
Do you exercise? □No □Yes, what and how often? ____
How is your general food diet? □Very healthy □Questionably healthy □Not very healthy □Always changing
How is your sleep? □Excellent □Good □Fair □Poor How many hours per night do you usually sleep? ____________
How is your general health? □Excellent □Good □Fair □Poor

Emergency Care Information

Personal Physician: Name: ____Phone: ______________________
First Last
Address: ____
Street City State Zip
Person to be contacted in case of an emergency:

Name: ____Phone: ____________________________

Family Background

Have any family members had any moderate to severe psychological or medical problems? If so, please describe:

____

____

Please describe your family relationships: ____

____

Social/Occupational Functioning

How is your social network? □No close friends □One close friend □Few friends □Many friends
How often do you make contact with friends? □Regularly □Occasionally □Infrequently □Never
Are you satisfied with your social relationships? □Yes □No, explain ____
Are you able to talk to others about the concerns that bring you into therapy? □No □Yes
What is you living situation? □Live alone □With others, with whom? ____
How do you feel about your (circle one) work/school? □Pleased □Mostly satisfied □Mixed □Mostly dissatisfied
□Unhappy
Major dissatisfaction with (circle one) work/school? ____

Please describe any hobbies or recreational activities: ____

____