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Client Information Form

Welcome to my practice. I look forward to helping you reach your goals. Please print and bring this completed form to your initial session. The questions on the following pages are designed to orient me best to your treatment needs. If you have any questions, I will be happy to answer them.

Today's date: _____

Note: If you have been a patient here before, please fill in only the information that has changed.

A. Identification

Your name: _____ Date of birth: _____ Age: ____

Nicknames or aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Mobile phone: _____ Work phone: _____

Email: _____

Calls or email will be discreet, but please indicate any restrictions: _____

Current Relationship Status: _____

Current Occupation/Employer: _____

B. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Have you ever met with a psychologist, psychiatrist or counselor in the past? ❑ Yes ❑ No
If yes, name of provider: _____ Dates of treatment: _____

Have you ever received intensive treatment or been hospitalized for emotional health concerns? ❑ Yes ❑ No
If yes, name of facility: _____ Dates of treatment: _____
What did you receive treatment for? _____

C. Emergency information

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

D. Please explain what brings you to therapy at this time:

_____

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E. Please mark all items that describe your current concerns and symptoms:

_____ Abuse – physical, sexual, emotional, neglect
_____ Adjusting to changes in your life
_____ Aggression, anger, temper problems
_____ Alcohol use
_____ Anxiety, nervousness
_____ Attention, concentration, distractibility
_____ Body image concerns
_____ Career concerns, goals, choices
_____ Childhood issues (your own childhood)
_____ Chronic Pain or Fatigue
_____ Conflict with others
_____ Confusion
_____ Custody of children
_____ Cutting, hitting or burning yourself
_____ Decision making, indecision, mixed feelings
_____ Delusions (false ideas)
_____ Depression, low mood, feeling down
_____ Desire to change a behavior
_____ Divorce
_____ Drug use- prescription medications, street drugs
_____ Eating problems – overeating, undereating, appetite, vomiting
_____ Emptiness
_____ Family issues
_____ Grief
_____ Identity problems
_____ Impulsiveness, loss of control, outbursts
_____ Judgment problems
_____ Learning disability
_____ Legal problems
_____ Marital conflict
_____ Memory problems
_____ Mood swings
_____ Nervousness
_____ Obsessions, compulsions (thoughts/actions that repeat)
_____ Panic attacks or intense fears
_____ Parenting
_____ Perfectionism
_____ Physical disability
_____ Procrastination
_____ Relationship problems (friends, relatives, work)
_____ School problems
_____ Self esteem or personal growth
_____ Sexual issues, dysfunctions, conflicts, desire
_____ Shyness, oversensitivity to criticism
_____ Sleep problems- too much/little, insomnia, nightmares
_____ Smoking and tobacco use
_____ Social skills or loneliness
_____ Spiritual, religious, moral, ethical issues
_____ Suicidal thoughts
_____ Weight and diet issues
_____ Withdrawal, isolating
_____ Work problems

F. Referral: How did you learn of this therapy practice?

Name: _____ Phone: _____

May I have your permission to thank this person for the referral? ❑ Yes ❑ No
How did this person explain how I might be of help to you? _____

_____

G. Is there any other information you think would be helpful to know?

_____

_____

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