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Client Information Form

Please print clearly as you complete the form below and bring it to your first session. For privacy reasons, please do NOT email this form.

Today's Date: _____

Contact Information

Name of person completing form & relationship to client:_____

Name:_____
(Last) (First) (Middle Initial)

Date of Birth:_____ Age:_____ Gender: _____ Ethnicity:_____
Address_____ City_____ State_____ Zip_____
Phone number: _____ OK to leave a message on this number? □ Yes □ No
Alternate (or minor's) phone number: _____ OK to leave a message on this number? □ Yes □ No
Email address*: _____OK to contact you via email? □ Yes □ No
**Please note that privacy via email is not guaranteed, as email is not a secure form of communication.*

Preferred Language: _____ Referral source:_____
Relationship Status (check all that apply): □ Never Married □ Single□ Married □ Widowed □ Separated □ Divorced
□ Living Together □ Living Apart □ Cohabitating □ Dating
Children and Ages (if applicable):_____
Others living in the home (if applicable):_____

Work Information
Employer name: _____Employer address: _____City:_____ State:___ Zip:_____
Employment status: □ Full-time □ Part-time □ Seasonal □ Stay-at-home parent □ Retired □ Unemployed □Other □N/A

Emergency Contact:
Name: _____ Relationship:_____ Phone number:_____

Insurance Information (if applicable)
Primary Insurance_____ Subscriber_____
Phone_____ Subscriber Date of Birth _____
Contract/ID#_____ Client's relationship to Subscriber
Group/Acct#_____ __Self __Spouse __Child __Other_____

Person Responsible for Payment (Please print)_____ Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____

Personal and Family History

Have you received prior therapy or other mental health treatment? □ Yes □ No

If YES, please list any past diagnoses: _____

If YES, please list name of therapist(s) and approximate date(s) of treatment:_____

Have you ever been hospitalized for psychiatric reasons? □ Yes □ No

If YES, please list any past hospitalizations, including the year and reason for hospitalization: _____

Have you taken any psychiatric medications in the past? □ Yes □ No

If YES, Please list any past medications: _____

Does anyone in your family have mental illness? : □ Yes □ No

If YES, please explain: _____

Does anyone in your family have a substance abuse problem? : □ Yes □ No

If YES, please explain: _____

Current Situation

What brings you to therapy at the current time? _____

Please describe when the above issue(s) first began, and how long they have lasted:

_____

What current stressor(s) do you have?_____

_____

What do you consider to be your strengths?_____

_____

What do you consider to be your weaknesses? _____

_____

What have you already done to try to remedy your problem(s)_____

_____

Do you currently take ANY medication? □ Yes □ No

Please list ALL current medications and dosages if known:_____

_____

Do you currently see a psychiatrist or other prescribing professional? □ Yes □ No If YES

Psychiatrist's name: _____ Phone number: _____

What is the approximate date of your last physical?_____ Past medical problems (include any hospitalizations):_____

_____

Current medical problems: _____

_____

Symptom Checklist

Please check if any of the following are past or current concerns or problems.

Anxiety	□ Past □ Current	Sexual orientation	□ Past □ Current
Depression	□ Past □ Current	Grief/loss	□ Past □ Current
Eating/ food concerns	□ Past □ Current	Drug use/abuse	□ Past □ Current
Alcohol use/abuse	□ Past □ Current	Marital/relationship difficulties	□ Past □ Current
Traumatic events	□ Past □ Current	Physical health/illness	□ Past □ Current
School behavior problems	□ Past □ Current	Financial concerns	□ Past □ Current
Academic difficulties	□ Past □ Current	Religion/ spirituality	□ Past □ Current
Concerns about sex	□ Past □ Current	Gender identity	□ Past □ Current
Legal concerns	□ Past □ Current	Body image concerns	□ Past □ Current

Please list other concerns or problems not listed above:

_____