CLIENT INFORMATION FORM

This Form is Confidential

Today's date: ________________________________

Your name: ____
Last First Middle Initial

Gender: ___________ **Race/Ethnicity** ___________________**Age** _______________________

Date of birth: _______________ **Social Security #:** _______________________________________

Home street address: ____

City: _______________________________________ **State:** _______**Zip:**______________________

Name of Employer:____

Address of Employer: ____

City: _______________________________________ **State:** _______**Zip:**______________________

Home Phone: _________________________ **Work Phone:** _________________________________

Cell Phone: __________________________ **Email:** _______________________________________

Please state where we may leave messages? [ ] cell [ ] home [ ] work [ ] email [ ] none

Person(s) to notify in case of any emergency: ____
Name Phone

I will only contact this person if I believe it is a life or death emergency. Please provide your initials to indicate that I may do so:): ______

Please briefly describe your presenting concern(s): ____

____
____
____
____
____

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

MEDICAL HISTORY:

Please explain any significant medical problems, symptoms, or illnesses:

____
____
____

Current Medications:

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

Please indicate if you use any of the following substances and your frequency of use.

Substance	Yes	No	Amount
Cigarettes/Tobacco Products			
Marijuana			
Vaping			
Alcohol			
Opioids			
Other-Specify:			
Other-Specify:			

Have any of your friends or family members voiced concern about your substance use? [ ] Yes [ ] No

Have you ever been in treatment because of your substance use? [ ] Yes [ ] No

If YES, list dates ____
Inpatient? [ ] Yes [ ] No
Treatment Facility/Provider: ____

Have you had a history of abuse, neglect and/or trauma? [ ] Yes [ ] No
If yes, briefly describe:

Previous ***medical*** hospitalizations:

Name of hospital	Approximate Dates	Reason

Previous ***psychiatric*** hospitalizations:

Name of hospital	Approximate Dates	Reason

Outpatient **mental health** treatment

Name of Provider	Approximate Dates (mm/yy-mm/yy)	Reason

Current and Previous **psychiatric** medications:

Medicine	Prescribed by (e.g. primary care, psychiatrist)	Dates taken	Reason

FAMILY/RELATIONSHIPS:

Marriage/Life Partner	Dates	# Children from relationship
Children Names	Ages	Live in household?

Who raised you?	Relationship (e.g. parent/step-parent/grandparent, etc.	Living?	City/State of Residence

Other important family relationships	Relationship (e.g. brother, sister, cousin, aunt, etc.)	Living?	City/State of Residence

Current level of satisfaction with your friends and social support: POOR 1 2 3 4 5 6 7 EXCELLENT

Is spirituality important in your life and if so please explain:_______________________________________
____

EDUCATION & CAREER

Please describe your education:

Did you graduate high school? [ ] Yes [ ] No If yes, what year? __________________________

Did you acquire a GED? [ ] Yes [ ] No If yes, what year? __________________________

Additional Education

Name of Institution	Degree Received	Dates Attended

What is the longest period of time you held the same job? ___________________________________

What were the dates of employment? ____

What line of work? ____

PLEASE CHECK ALL THAT APPLY & ***CIRCLE*** THE MAIN PROBLEM:

DIFFICULTY WITH:	NOW	PAST			DIFFICULTY WITH:	NOW	PAST			DIFFICULTY WITH:	NOW	PAST
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					Employer					Chest Pain		
Concentration					Finances					Lump in the Throat		
Headaches					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					Waking Too Early					Easily Distracted by Noises		
Severe Weight Loss					Nightmares					Hyperactivity		

Thank you. Please give this form to your therapist.