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Client Information form

Please provide the following information and answer the questions below. Please note: the information that you are providing is protected as confidential information.

Name: _____ Date: _____
Gender: _____ Date of birth: _____
Address:_____
_____
Social Security #: _____
Home phone: _____ Cell phone: _____
Email: _____ May I email you? yes_____ no _____
Referred by: _____
Employer: _____ Occupation: _____
Employer's Address: _____
_____
Work phone: _____ May I call at work? yes _____ no ____

Sexual Orientation: _____
Relationship status: single__ partnered__ married ___ separated____
divorced___ widowed ____
Partner's name: _____ Children (how many): _____

Emergency Contact: _____
Relationship: _____ Phone number: _____
Family Physician (name & phone):
_____

Person Responsible for Payment: _____Self _____Other

Does your insurance cover outpatient psychotherapy: yes _____ no_____
Carrier Name: _____
Address: _____
_____
Group Number: _____ Policy Number: _____
Subscriber Number: _____ Phone: _____

If someone other than you is responsible for payment:
Name of responsible person: _____
Social Security #: _____ Date of birth: _____
Employer: _____

Please respond to the following questions.
If you have questions or concerns about any item, please discuss it with me when we meet. Thank you.

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific health problems you are currently experiencing:

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2. How would you rate your current sleeping habits? (please circle)
   Poor Unsatisfactory Satisfactory Good Very Good

   Please list any specific sleep problems you are currently experiencing:

---

3. How many times per week do you generally exercise? _____

   What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

   _____

5. Are you currently experiencing overwhelming sadness, grief, or depression? No___ Yes___

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias? No___ Yes___

If yes, please describe and when did you begin experiencing this?

_____

_____

7. Are you currently experiencing any chronic pain? No___ Yes___

If yes, please describe:

_____

8. Do you drink alcohol more than once a week? No___ Yes___

9. How often do you engage in recreational drug use? Daily___ Weekly___

   Monthly___ Infrequently___ Never___

10. Are you currently in a romantic relationship? No___ Yes___

    If yes, for how long? _____

    On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

    _____

_____

FAMILY AND MENTAL HEALTH HISTORY

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, mother, grandmother, uncle, etc.)

_____ Please Circle_____ List Family Members____

Alcohol/substance abuse	No/Yes
Anxiety	No/Yes
Depression	No/Yes
Domestic Violence	No/Yes
Eating Disorders	No/Yes
Obesity	No/Yes
Obsessive Compulsive	No/Yes
Schizophrenia	No/Yes
Suicide Attempts	No/Yes

ADDITIONAL INFORMATION

1. Are you currently employed? No___ Yes___
If yes, what is your current employment situation:

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? No___ Yes___
If yes, describe your faith or belief:

_____

_____

3. What do you consider to be some of your strengths?

_____

_____

4. What do your consider to be some of your challenges/weakness?

_____

_____

5. Briefly describe your reasons for seeking therapy:

_____

_____

6. Have you ever sought therapy in the past?
If yes, please list therapist's name and dates of treatment.

_____

_____

_____

7. Are you currently seeing another mental health provider?
If yes, list mental health providers name and contact information:

_____

_____

8. Have you ever been hospitalized for psychiatric reasons?
If yes, please list hospitals, dates and reason for hospitalization:

_____

_____

_____

9. Have you ever made a suicide attempt?
If yes, please elaborate:

_____

_____

List the names, dosages and frequency and prescribing physician of all medications you are presently taking:

_____
_____
_____
_____
_____

Have you ever felt threatened and/or been hurt in any way physically or emotionally by your current or past significant other or another person? If yes, please elaborate:

_____
_____
_____

What would you like to gain from coming to therapy?

_____
_____
_____

Anything else you feel I should know about you?

_____
_____
_____