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Client Information form

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

Name: _______________________________ Date: ___________________________
Address:____
____

Social Security #: _______________________________________
Gender: ___________________ Date of birth: ____________________
Race/Ethnicity: ____

Home phone: ___________________ May I leave a message? Yes____ No____
Cell phone: ______________________ May I text you? Yes____ No____
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/ages): ___________

Emergency Contact: ______________________________________
Relationship: _______________ Phone number: ______________

Family Physician/Primary Care Provider: (name & phone):
____

Referred by (if any):____________________________

Person Responsible for Payment: _____Self _____Other
Does your insurance cover outpatient psychotherapy: yes _____ no_____
Carrier Name: ____

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:

____

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 you consider to be some of your challenges/weakness?

____
____

5. Briefly describe your reasons for seeking therapy:

____
____
____
____

6. Have you ever sought treatment from a therapist/psychiatrist/psychiatric nurse practitioner in the past?
If yes, please list providers 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 medications, dosages, frequency and the 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?

____
____
____
____