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Client Information Form

Your cooperation in completing this questionnaire will be helpful in planning services for you. Please answer each item carefully and ask questions if something is not clear. The information provided on this questionnaire is confidential and will not be released without your permission.

Basic Information

Client Name (yourself or your child) ____

Maiden name (if applicable) ____

Address ______________________________ City/State____________________ Zip______________

Primary Phone # ______________________________ OK to leave messages? ☐ Yes ☐ No

Alternate Phone #______________________________ OK to leave messages? ☐ Yes ☐ No

Email Address ____

Date of Birth ____________________ Age ______ Ethnicity ______________________________

Gender: ______________________________ Relationship Status______________________________

Employment/Occupation (self or parent(s))____

Income ____________________ Per _________ Insurance______________________________

Religious/Spiritual Affiliation: ____

Highest Level of Education: ____

Emergency Contact Information

*In case of an emergency, please list the name, address, and phone number of **two** people that are **not** in therapy with you that I would be able to contact.*

Contact #1:

Name: ______________________________ Relationship: ______________________________

Phone Number: ____

Address: ______________________________ City/State: ______________________________

Contact #2:

Name: ______________________________ Relationship: ______________________________

Phone Number: ____

Address: ______________________________ City/State: ______________________________

Please sign below, giving your consent to allow your therapist to contact these individuals in an emergency situation, as deemed so by your therapist.

Signature: ____Date: ___________________

If applicable, please list all family members currently residing in your household:

Name of Family Members	Age	DOB	Relationship to Client
____	______	_________	_______________________________
____	______	_________	_______________________________
____	______	_________	_______________________________
____	______	_________	_______________________________
____	______	_________	_______________________________
____	______	_________	_______________________________

How many people live in your home, including yourself? ________

Medical History

Please answer the following questions to the best of your knowledge

Physician _________________________________ Approximate Date of Last Visit __________________________

Current Medications/Dosages ____

Significant Medical Conditions ____

Please list the type and amount of alcohol or drugs used currently: ____

____

Additionally, please describe any past or current problems with alcohol or drug abuse (including

attempts to quit or cut down, past treatment, arrests, DUIs, etc.) ____

____

Have you/your child previously received any psychiatric, psychological, and/or counseling help? Yes No
If yes, please describe briefly ____

____

Other Relevant Information

If applicable, what is the name, age, and gender of your current spouse or partner?

Name: ____ Age: ______________ Gender: ____________________

Do you feel safe in your current relationship?

Physically: Yes No

Emotionally: Yes No

Do your arguments escalate out of control? (circle one) Never Rarely Occasionally Very Often

Please list and describe any significant family events you would like for me to know about (i.e., deaths, moves, divorce, etc.): ____

____

____

____

Briefly describe your reason for seeking help ____

____

____

____

Who suggested you contact me? ____

<u>Please circle any of the following concerns you, your child, or your family may be experiencing:</u>

Nervousness	Toileting	Suicidal Thoughts
Shyness	Depression	Finances
Separation/Divorce	Sexual Problems	Unhappiness
Drug Use	Alcohol	Work
Anger	Self Control	Tiredness
Sleep	Stress	Ambition
Relaxation	Headaches	Decision Making
Legal Matters	Memory	Concentration
Energy	Insomnia	Health Problems
Loneliness	Feeling Inferior	Marriage
Education/School	Nightmares	Death of Loved One
Behavioral Problems	Appetite/Eating	Marital Problems
Temper	Parenting	Stomach Trouble
Children	Fears	Thoughts
Other: ______________________		

Please list any other information that you feel may be helpful to me: ____

____

____

Thank you for completing this questionnaire!