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CLIENT INFORMATION FORM

A. Identification

Your name: _____ Date of birth: __ __/__ __/__ __ __ __

Nicknames/aliases: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip:_____

Home phone: _____ Cell phone: _____

Work phone: _____ E-mail: _____

Calls or e-mail will be discreet, but please indicate any preferences or restrictions:_____

_____

B. Demographic Information

Age: _____ Race/ethnicity: _____

Highest level of education completed: _____

Occupation: _____ Employer: _____

Employer's address: _____

Did you ever serve in the military? ❑ Yes ❑ No If yes, did you ever see combat? ❑ Yes ❑ No

Branch: _____ MOS:_____

Current religious affiliation: ❑ Christian (specify): _____ ❑ Jewish ❑ Islamic

❑ Buddhist ❑ Hindu ❑ Other (specify): _____

Religious Involvement: ❑ None ❑ Some/irregular ❑ Active

How important are spiritual concerns in your life? ❑ Not Important ❑ Somewhat Important

❑ Important ❑ Very Important

Current romantic relationship status: ❑ Single ❑ Long-term Partnership ❑ Married ❑ Divorced

❑ Widowed ❑ Other (specify): _____

Length of current relationship: _____

Do you have children? ❑ Yes ❑ No

If yes, please complete the following table. In the last column, designate children from a previous marriage/relationship with a "P" and stepchildren with an "S."

Name	Age	Sex	School/Occupation	Grade	Indicate any adjustment problems	P? S?

Please list family, friends and other key persons in your life. If the person is deceased, please indicate that by placing a "D" in the last column.

Name	Age	Sex	Relationship to you	Occupation	Marital Status	D?

C. Referral Source

How did you hear about my services? _____

May I have your permission to thank your referral source for the referral (if applicable)? ❑ Yes ❑ No

D. Insurance Information

Do you intend to use insurance to pay for services? ❑ Yes ❑ No

If yes, please provide your primary insurance information:

Insurance Company Name: _____

Subscriber's Name: _____

Subscriber's Employer: _____

Subscriber's Identification #_____

Group ID#_____

Subscriber's Date of Birth ____/____/_____

Subscriber's Phone Number _____

Client's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

E. Emergency information

If some kind of emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Address: _____

Please provide the name of a <u>local</u> friend or relative ***<u>not</u>*** residing with you:

Name: _____ Relationship: _____

Phone 1: _____ Phone 2: _____

Address: _____

F. Health Information

How would you rate your current physical health?

❑ Poor ❑ Average ❑ Good ❑ Excellent

Please list any specific health problems you are currently experiencing: _____

_____

How would you rate your current sleeping habits?

❑ Poor ❑ Average ❑ Good ❑ Excellent

Please list any specific sleep problems you are currently experiencing: _____

_____

How many times per week do you generally exercise? _____

What types of exercise do you participate in: _____

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

_____

Are you currently experiencing chronic pain? ❑ Yes ❑ No

If yes, please describe: _____

How many alcoholic drinks *a week* do you consume? _____

Have you ever felt like you need to cut down on your drinking? ❑ Yes ❑ No

How many caffeinated beverages *a day* do you consume? _____

Which drugs (not medications prescribed to you) have you used in the last 10 years? _____

_____

Have you ever experienced physical, sexual and/or emotional abuse or neglect? ❑ Yes ❑ No

Please describe the kind of abuse/neglect, when it occurred, by whom and the effects on you: _____

_____

_____

Are you currently experiencing any of the following (check all that apply):

❑ Anger, hostility, irritability ❑ Anxiety, nervousness ❑ Attention/concentration problems, distractibility ❑ Career concerns/school problems ❑ Issues with your own childhood/growing up experiences ❑ Codependence ❑ Confusion ❑ Compulsions ❑ Custody of children ❑ Indecision/putting off decisions ❑ Delusions (false ideas) ❑ Dependence ❑ Depression, low mood, sadness, crying ❑ Divorce, separation ❑ Drug use ❑ Eating problems ❑ Emptiness ❑ Failure ❑ Fatigue, tiredness, low energy ❑ Fears/phobias ❑ Financial problems ❑ Problems with friends

❑ Gambling ❑ Grieving/loss ❑ Guilt ❑ Headaches ❑ Inferiority feelings ❑ Interpersonal conflicts ❑ Impulsiveness/loss of control ❑ Irresponsibility ❑ Legal matters ❑ Loneliness ❑ Marital conflict/disappointment ❑ Memory problems ❑ Menstrual problems, PMS, menopause ❑ Mood swings ❑ Lack of motivation ❑ Obsessive thoughts ❑ Oversensitivity to rejection ❑ Panic/anxiety attacks ❑ Parenting difficulties ❑ Perfectionism ❑ Procrastination ❑ Relationship problems ❑ Self-centeredness ❑ Low self-esteem ❑ Self-neglect/poor self-care ❑ Sexual issues ❑ Shyness ❑ Spiritual concerns ❑ Stress ❑ Suspiciousness ❑ Suicidal thoughts ❑ Temper problems/low frustration tolerance ❑ Threats, violence ❑ Weight/diet issues ❑ Withdrawal/isolating ❑ Work problems/conflict

Please list the physician(s) from whom you receive your medical care, *including your primary care physician*. Describe any conditions for which you are receiving treatment, and include the medications you are taking along with the dose for each.

Physician's Name	Phone	Primary Care or Specialist?	Diagnosis/Conditions Treated	Medications Prescribed & Dose

May I tell your medical doctor(s) that you are in treatment with me, so that he/she/they can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Are you currently seeing a psychiatrist for medication management? ❑ Yes ❑ No

Psychiatrist's name: _____

Phone: _____ Treatment start date: _____

Diagnosis (if known): _____

Medication(s) prescribed & dose: _____

_____

May I tell your psychiatrist that you are in treatment with me, so that he/she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Have you ever seen a therapist or counselor in the past? ❑ Yes ❑ No

Therapist's name(s): _____

Phone: _____ Dates of treatment: _____

Diagnosis (if known): _____

Problems/issues addressed: _____

_____

May I contact your previous therapist(s)/counselor(s) to obtain additional information about your prior treatment to assist us in our work together? ❑ Yes ❑ No

G. Treatment Focus

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

_____

_____

Please describe any significant life changes or stressful events that you have recently experienced:

_____

_____

_____

_____

_____

Please describe your hopes or goals for therapy: _____

_____

_____

_____

_____

_____

Please provide any other information you think would help with your treatment: _____

_____

_____

_____

_____

_____