CLIENT INFORMATION FORM

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Welcome to my practice. Please take a few minutes to fill out the following form. This information will help me to better understand you and your specific needs. Thank you.

Today's Date _____

Client Name: _____
(To be completed by the Parent/Guardian if patient is younger than 18 years)

Date of Birth _____ **Age:** _____

Address _____
Street address **City** **State** **Zip**

Email Address_____

Insurance / ID# /Subscriber name/Date of Birth _____

_____

Phone Number(s): **Home** _____ **Work** _____ **Cell** _____

May I call you **...at home?** □ **yes** □ **no** **...at work?** □ **yes** □ **no**

Current Relational Status: Single Married Divorced

Please list all of your children:

Name _____ **Age**_____

Name _____ **Age**_____

Name _____ **Age**_____

Name _____ **Age**_____

Employer/School_____**Occupation**_____

Referral source: _____

Person to be contacted in case of an emergency:

Name _____ **Phone:** _____

Relationship : _____

Please describe your reasons for seeking counseling (presenting problems):

_____

_____

_____

_____

_____

Have you had therapy prior to today: Yes No
If yes—please tell me when: _____

Please place a checkmark next to any areas of concern that pertain to you and/or family (please indicate which relative):

	SELF	Mother	Father	Sibling
Depression (for greater than 2 weeks)				
Anxiety				
Failure to graduate from High School				
Learning Disabilities				
Childhood Aggression				
Alcohol/Substance Abuse				
Physical Abuse				
Emotional/Verbal Abuse				
Sexual Abuse				
Self-Harm (ex: cutting, burning)				
Arrests/Legal troubles				
Suicidal thoughts/attempts				
Psychosis/Schizophrenia				
Impulsivity				
Problems controlling anger/temper				

Please list any serious medical conditions that you are or have been treated for:

_____

_____

_____

_____

Please list any medications you are taking (name, dose and frequency): _____

_____

_____

_____

When did you last have a physical examination? _____

Name and phone number of primary physician: _____

Please describe any current or past problems with substance abuse:

_____

_____

_____

Please add any information that you would like me to know that is relevant to your treatment:

_____

_____

_____

_____