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CLIENT INFORMATION FORM

Please fill out this form and then e-mail it, fax it, or mail it to me before your first appointment.

1. CLIENT DATA: Today's date: _____

Name:_____ Pronouns:_____ Date of birth: _____

Address: _____ City: _____ St: _____Zip: _____

Home phone: _____ Work: _____ Cell phone: _____

E mail: _____ Is it okay to communicate with you by email? □ Y □ N

Employer Name & City: _____

School Name & City (if currently a student): _____

Ethnic identity? _____

2. REFERRAL SOURCE: (How did you find me? Please include name and phone number if known.)

□ Therapist _____ □ Physician _____ □ Attorney _____

□ Word of mouth (friend, former client) _____ □ Business card/brochure

□ My website _____ □ Other website _____

□ Other _____

3. EMERGENCY CONTACT:

Name:_____ Address: _____

Phone_____ E mail _____

Relationship to you:_____

4. COMPOSITION OF PRESENT HOUSEHOLD: (check all that apply)

□ Living alone □ With spouse/partner □ With parents or guardians

□ With dependent children □ With adult children □ With in-laws

□ With roommate(s) □ Other arrangement _____

5. MARITAL/RELATIONSHIP STATUS:

□ Not currently married or partnered

□ Never married or partnered

□ Widowed

□ Divorced

□ Separated

□ Currently married/partnered (how long?) _____

6. MARITAL/RELATIONSHIP HISTORY:

# of marriages or partners_____

# of living children _____

Their ages and genders _____

# of deceased children _____

If not partnered, length of longest relationship__

_____

7. HIGHEST EDUCATIONAL LEVEL: (Check all that apply, indicate where/when)

□ Less than high school
□ Some high school
□ Graduated high school
□ Trade/professional school
□ Jr. College (AA degree)
□ College (no degree)
□ College (graduated)
□ Some graduate school (no degree)
□ Masters degree or equivalent
□ Doctoral degree or equivalent

8. CURRENT EMPLOYMENT:

□ Homemaker
□ Unemployed (for how long?) _____
□ Full or part-time student. Where/studying what? _____
□ Working full or part-time. Where? Doing what? _____
Ever been in military? □ No □ Yes Which branch/total time in service? _____

9. OCCUPATIONAL CLASSIFICATION:

□ Professional
□ Education
□ Unskilled
□ Skilled
□ Semi-skilled
□ Science/technology
□ Managerial
□ Visual or performing arts
□ Sales

10. RELIGIOUS/SPIRITUAL AFFILIATION:

Yours (past and present) _____
Father's _____ Mother's _____
Have religious beliefs or spirituality been important for you?
□ No □ Yes, currently □ Yes, but in the past

11. YOUR MEDICAL HISTORY:

Date of your last complete physical exam? _____ Findings: □ OK □ Problems? _____
If you are currently under treatment or evaluation for any medical problems, what is the issue and who is your physician (name, phone #, address) _____
For the following, please describe, give your age at the time each happened and indicate if there were any complications…
Major illnesses _____
Operations _____
Accidents requiring trips to the hospital _____
Head injuries (even minor ones) _____
Allergies _____
Other (please describe) _____
List current prescription medications and non-prescription (over the counter) supplements or vitamins that you are taking please include(dosage, frequency, and reason for taking): _____
_____

□ Significant problems with PMS (pre-menstrual syndrome)
□ PMDD (Pre-Menstrual Dysthymic Disorder)
□ Taking hormone replacement therapy
□ Problems related to peri-menopause
□ Problems related to menopause
□ Other menstrual problems? _____

12. SLEEP PROBLEMS:

□ None □ Chronic night owl
□ Chronic difficulty falling asleep at "normal" bedtime (10 PM-midnight)
□ Chronic sleep deprivation (less than 5.5 hrs. of sleep per night)
□ Problems staying asleep □ Sleep apnea
□ Use a CPAP machine □ Take sleep medications (which ones?) _____

13. ITEMS YOU KNOW OR SUSPECT APPLY TO YOU:

□ Survivor of physical, sexual, verbal, or emotional abuse _____
□ Perpetrator of physical, sexual, verbal, or emotional abuse _____
□ Survivor of domestic violence _____
□ Perpetrator of domestic violence _____
□ Alcohol and/or drug abuse _____
□ Other abuse/addiction (e.g., food, sex, gambling, internet porn) _____
□ Criminal involvement _____
□ Current legal problems _____
□ Violent behavior _____
□ Suicide potential/thoughts/attempts _____

14. YOUR SUBSTANCE USE HISTORY:

Do you consume more than three caffeinated beverages per day (coffee, tea, soda, etc.): □ No □ Yes
Do you use nicotine (cigarettes, pipe, cigars, snuff, etc.)? □ Yes □ No, but I used to □ No, never
Briefly describe your current alcohol and/or drug use and any significant history, if it differs

_____
_____
_____

15. PREVIOUS THERAPY (from a mental health professional, physician, clergy, etc.)?

□ No □ Yes If "yes", please list

Therapist's Name Address/ Phone # Dates & Number of Visits

_____
_____
_____
_____

16. YOUR REASONS FOR SEEKING HELP AT THIS TIME: Below is a list, though not exhaustive, of problems for which people sometimes seek treatment. Please indicate the extent to which each is (or is not) a problem for you *at the present time*.

0 = Not a problem or not applicable
1 = Slight problem
2 = Moderate problem
3 = Serious problem
4 = Severe problem

___ Time management, procrastination, getting motivated
___ Decisions about work/job/career
___ Loneliness
___ Relationships with friends
___ Relationship with romantic partner/spouse
___ Break up, separation or divorce
___ Self-confidence and self-esteem issues
___ Anxiety, fears, worries
___ Feeling overwhelmed
___ Generally unhappy, dissatisfied
___ Confusion over personal/religious values/beliefs
___ Issues/concerns related to sexual orientation
___ Issues/concerns related to gender identity
___ Depression
___ Grief over death or loss
___ Suicidal thoughts/feelings
If other than "0", please indicate your overall risk of suicide:
□ very low risk □ low □moderate □high □very high
___ Attempted suicide □Yes □No
___ Eating concerns
___ Alcohol/drug problem
___ Family concerns about your alcohol or drug use
___ Alcohol/drug use in your family
___ Sexual abuse or assault, as a child or adult
___ Concern about physical health, medical problems
___ Sexual issues
___ Sleep problems
___ Pregnancy concerns
___ Violent thoughts, feelings or behaviors

17. OTHER IMPORTANT INFORMATION: Please review your answers so far, and describe here anything else that you think I should know to better understand your current concerns:

_____
_____
_____
_____
_____

Thank you for taking the time to complete this form. I look forward to meeting with you in person.