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Client Information Form

Today's Date: _____

General Information

Name: _____ Date of Birth: _____ Age: _____
Current Address: _____
Home Phone: _____ Cell: _____ Work: _____
Best number to reach you directly: _____
Email: _____
Employer: _____
How long at present job? _____
Who referred you to me? _____
How did this person explain that I might be of help to you? _____
_____
_____

Family Information

Marital Status: _____ Spouse's Name: _____ Spouse's Age: _____
Spouse Occupation: _____ Years Married: _____
Previous Marriages: ☐ Yes ☐ No If yes how many times have you been married? _____

Children's Names	Age	Sex	Relation	At home?
_____	____	____	_____	_____
_____	____	____	_____	_____
_____	____	____	_____	_____
_____	____	____	_____	_____

Were your parents: ☐ Divorced ☐ Never Married ☐ Still Married ☐ Widowed
Names and ages of your siblings: _____
_____
Where were you in the birth order of siblings in your family? _____

Family History of:

□ Depression □ Suicide Attempts □ Anxiety □ Eating Disorders □ Mental Illness
□ Violence □ Sexual Abuse □ Emotional/Verbal/Spiritual Abuse
□ Alcoholism/Drug Addiction
□ Chronic Illness (please explain): _____
□ Other: _____

Please indicate any of the following you have experienced:

□ Death of Mother Your age at occurrence _____
□ Death of Father Your age at occurrence _____
□ Death of Child Your age at occurrence _____
□ Death of Sibling Your age at occurrence _____
□ Desertion by mother as child Your age at occurrence _____
□ Desertion by father as child Your age at occurrence _____
□ Divorce of parents Your age at occurrence _____
□ Sexual Abuse Your age at occurrence _____ By Whom? _____
□ Physical Abuse Your age at occurrence _____ By Whom? _____
□ Violence in the Family Your age at occurrence _____ By Whom? _____
□ Mental Illness of a family member Your age at occurrence _____ Which Member_____

Medical information

Primary Physician: _____ Phone: _____
Major (or Chronic) Illnesses/Operations/Injuries: _____
_____
_____
Current Medications: _____
Have you experienced any recent changes in: □ Sleep □ Nightmares □ Amount of exercise
□ Weight □ Eating/Appetite □ Alcohol Intake □ Sexual Desire □ Stamina □ Energy
How would you characterize your overall health? □ Excellent □ Good □ Fair □ Poor

Chemical Use:

Have you ever felt the need to cut down on your drinking? □ No □ Yes
Have you ever felt annoyed by criticism of your drinking? □ No □ Yes
Have you ever been in a drug or alcohol treatment program? □ No □ Yes
Have you ever felt guilty about your drinking? □ No □ Yes
How much beer, wine, or hard liquor to you consume each week on average? _____
Do you use tobacco or chew? □ No □ Yes
Which drugs(not medications prescribed for you) have you used in the last 10 years? _____
_____

Treatment Information

Have you ever received psychological or psychiatric counseling before? ☐ Yes ☐ No

Counselor's Name: _____

Reason for past counseling: _____

_____

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

_____

_____

_____

Indicate the severity of you problem on the scale below:

☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe ☐ Incapacitating

Please indicate the major stressors in your life in the last twelve months:

☐ Serious injury/illness ☐ Death of a close friend or relative ☐ Major illness in the family

☐ Divorce/Separation ☐ Job Change ☐ Gain of a new family member

☐ Other (please describe) _____

Please describe what you would like to be different in your life when you are done with therapy:

_____

_____

Have you ever thought about suicide? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

Are you required by a court, the police, or a probation or parole officer to have this appointment?

☐ No ☐ Yes if yes please explain: _____

Is there anything else important for me as your therapist to know about, and that you have not written on these forms? If yes, please tell me about it here or on another sheet of paper:

_____

_____

_____

Client Signature:

_____