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CLIENT INFORMATION

Please take the time to fill out this confidential client information form prior to your first session. This information will help me get to know you and facilitate the beginning of your therapy.

Client _____ Date of Birth: ___/___/___ *Current Age _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: (____) _____ Home Phone: (____) _____ Work Phone (____) _____

Sex: Male Female Highest level of education and school attended _____

Employer/School _____ Job Title/Grade _____

Marital Status: Married Single Divorced Widowed Partner's Name _____

Emergency Contact: _____ Telephone: (____) _____

Referred by: _____

Sign here for permission to send thanks if a professional referred you: _____

Relevant medical conditions (history, current condition, changes in condition):

Medications (dosage, dates of initial prescriptions, name of prescribing professional):

Allergies/adverse reactions to treatment: : _____

Primary Care Physician Name: _____ Telephone _____

Date of last medical/physical exam _____

Reason for seeking therapy _____

Treatment Goals _____

Past therapy or psychiatric treatment _____

What, if anything, was helpful? : _____

Psychiatric hospitalizations (Dates and Locations): _____

Family History of therapy, psychological, or psychiatric treatment: _____

Do you drink coffee? Y or N (#_____cups/daily) Do you smoke Cigarettes? Y or N (#_____per day)

Alcohol? Y or N (#_____drinks weekly) Date last drank_____ Family History of Alcoholism? Y or N

Recreational Drug Use (Marijuana, Cocaine, Prescription Painkillers, Methamphetamine, etc.)? Y or N

Are you concerned about your drug/alcohol use? _____

Police / Probation involvement (past or present) Y or N Date_____ Please explain _____

Family Structure (who lives in your household? Please provide names, ages and relationship to each)

Please circle if you have experienced any of the following (past or present):

- | | | | |
|---------------------|-----------------------|---------------------------|---------------------|
| Mood Changes | Worry/Fear | Panic Attacks | Poor Concentration |
| Tearfulness | Fatigue | Feeling Hopeless/Helpless | Sleep Problems |
| Body Image Problems | Sexual Problems | Losses/Grieving | Phobias |
| Learning Problems | Spending Sprees | Outbursts of Anger | Lying |
| Drug/Alcohol Abuse | Pornography Addiction | Gambling Problems | Computer Addiction |
| Sexual Abuse | Domestic Violence | Traumas | Physical Abuse |
| Suicide Attempts | Suicidal Ideation | Loss/Grieving | Head Injury/Seizure |

Any other information you believe may be significant _____