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CLIENT INFORMATION FORM

Please answer all questions completely.
Use back of paper for additional space.

Full Name: _____ Date: _____

Home Phone: _____ Cell: _____

Work: _____ Email: _____

Is it okay to leave a message identifying the practice? Yes / No

Age: _____ Date of Birth: _____ Preferred Pronouns: _____
Referral Source: _____
Emergency Contact(s): _____
_____
_____

Home Address: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____

Current Employment: _____
Education: _____ Religion raised (if any): _____
Religion now (if any): _____ Ethnicity: _____
Sexual Orientation: _____ Gender you identify as: _____

What things do you do well? _____
_____
_____

What are your greatest strengths?

Why are you coming in for therapy now?

Are you currently in an intimate relationship(s)? Please describe:

Name of your partner(s) and occupation:

Do you have children? Please list names and ages:

Have you been in therapy before? Please describe (with whom, where, dates):

Have you even been diagnosed with a mental illness? Please explain:

Have you ever been hospitalized for psychiatric reasons? Please explain:

Have you even been suicidal? Please explain:

Are you currently taking any psychiatric medication? Please list the names of the medications, what they are prescribed for, and who prescribes them?

Medical History

Physician's Name: Phone:

Current Medications:

Prior Medication use and dates:

Do you currently have any physical health concerns?

Do you have any chronic illnesses?

Describe your sleeping patterns:

Describe your eating habits:

Do you drink alcohol? If yes, how much/how often?

Do you use substances? If yes, what do you use, how much, how often?

Describe your support system (family, friends, spiritual affiliations, etc.):

Are you currently involved or anticipate being involved in any legal proceedings?

Current symptoms. Please tell me which of the following, if any, are present in your life by circling one of the numbers after each item? (1 means not at all, and 5 means at a high level)

Easily stressed	1	2	3	4	5
Anxiety	1	2	3	4	5
Panic attacks	1	2	3	4	5
Irritability	1	2	3	4	5
Mood swings	1	2	3	4	5
Anger and explosivity	1	2	3	4	5
Feeling powerless when facing conflict	1	2	3	4	5
Thoughts of revenge	1	2	3	4	5
Nightmares	1	2	3	4	5
Difficulty sleeping	1	2	3	4	5
Difficulty relating to groups	1	2	3	4	5
Difficulty relating to intimate partner	1	2	3	4	5
Gastrointestinal complaints	1	2	3	4	5
Headaches and migraines	1	2	3	4	5
Back or neck pain	1	2	3	4	5
Widespread muscle tension	1	2	3	4	5
Feeling separate from your body	1	2	3	4	5
Feeling your surroundings are unreal	1	2	3	4	5
Intolerance to light and/or sound	1	2	3	4	5
Sexual problems or troubling fantasies	1	2	3	4	5
Eating disorders	1	2	3	4	5
Alcohol or drug dependence	1	2	3	4	5
Workaholism	1	2	3	4	5
Other addiction: specify _____	1	2	3	4	5
Low energy and fatigue	1	2	3	4	5
Depression	1	2	3	4	5
Feelings of loneliness	1	2	3	4	5
Low self-esteem	1	2	3	4	5
Shame	1	2	3	4	5

Goals for therapy

If therapy is successful, what will be different in your life? (Use reverse of sheet if you need more space)

Please include anything else you'd like me to know at this time or if there are questions that you would like to ask during our first meeting:

Signature: Today's date:

Thank you for your time in providing this information. This information will help me understand you and your needs better. I realize that you are being asked to provide a lot of information at this time. I invite you to bring your experience of this document to our first session. I would like to make this initial process as comfortable as possible.