Client Information Form
(Please print carefully)

Please take your time in providing the following information. The questions are designed to help me begin to understand you so that our time together can be as productive as possible. All information provided is confidential.

Name of client_____AGE_____Birthdate_____

Address_____

City_____State_____Zip_____

Employment_____

Phones (only used to call about appointments):

Home_____ OK to call? _____

Cell_____ OK to call? _____

Email_____ OK to contact?_____

Emergency Contact –

Name_____Phone_____

Referred by:

☐ Medical Provider: _____

☐ My Website ☐ Psychology Today

☐Friend/Family: _____ ☐Other: _____

Have you previously received any type of mental health services? ☐Yes ☐No

If yes, which of the following:

☐Psychotherapy
☐Medication
☐Outpatient
☐Inpatient Hospitalization

If yes, please provide:

Name of provider or facility:_____

Location:_____

Dates of treatment:_____

Reason for treatment:_____

Briefly, what brings you in today?_____

_____

When did your problem first start?

☐ Within the last: 30 days
☐ 6--12 months
☐ 2 years
☐ During adolescence
☐ During childhood

Please describe any major losses or traumas you have experienced: _____

_____

What significant life changes or stressful events have you experienced recently? _____

_____

What would you like to accomplish out of your time in therapy? _____

_____

_____

Family History:

Where were you born? _____

Where did you grow up? _____

Marital Status:

☐Never Married
☐Domestic Partner
☐Married
☐Separated Divorced -- For how long?
☐Widowed: Please provide your partners name and year deceased: _____

If married, what year did you get married:_____

Spouses Name: _____

Spouses Phone Number:_____ Email:_____

Spouse's Occupation_____

On a scale of 1-10 (best), how would you rate your relationship? _____

Please list any children, their names, and ages: Name Age Relationship Name of other parent

Name	Age	Relationship	Name of other parent	If deceased, age and cause of death

Please list your parents and siblings. Please use additional space on the back if needed

Name	Age	Relationship	If deceased, age and cause of death

Mother's occupation: _____

Father's occupation? _____

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Please circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Sexual Abuse	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Disorder	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	
Other diagnosed mental health condition?	yes/no	: which was---

Physical Health

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list.

_____

_____

_____

Please describe previous use of alcohol, cigarettes, and/or recreational drugs: _____

Additional Information:

_____

_____

_____

By signing below, you acknowledge that you:

- Have read, understand, and agree to all items on the consent form
- Have read and understand our Notice of Privacy Policies
- Have provided personal information that is completely true to the best of your ability

_____

Signed Date

_____

Signed Date