Client Information Form

Please complete the following questions to the best of your ability. Share as much as you are comfortable sharing. Any questions that you do not feel comfortable answering may be left blank. All information shared is confidential and is intended only to assist your clinician in providing the most informed care.

Client Name: ____ Current Age: ____________

In your own words, briefly describe the main reason you are here for care.

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What are you hoping that you will accomplish and how long are you expecting to be in therapy?

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____

Family Information

Spouse/Partner's name: ____ Length of relationship?: ______________

Number of marriages/committed relationships: ________ Previous spouse/partner's name(s): ____________________

____

What was your age when you first married/committed? _________________ How many children do you have? _______

Any step-, foster/adopted children?: ____

Please list your children's names and ages:

____

____

____

What are your parents'/guardians' names? ____

Parents'/Guardians' relationship status? _________ If divorced, your age when they divorced? ___________________

If divorced, did they remarry? _________________ What was your age when they remarried? ______________________

What are their ages if living? Mother ______________ Father ______________

What was their age at death if deceased? Mother ______________ Father ______________

Father's occupation: ____

Mother's occupation: ____

Names/relationships of any other significant caretakers in your life growing up:

____

____

____

How many siblings (biological, adopted, step, half, and other) do you have? ____________________________________

Please list their names and ages:

____

____

____

Do any blood relatives of yours have any mental health or substance abuse problems? ____________________________

Please describe:

____

____

____

Health Information

Please provide the name, address, and, phone number of your Primary Care Physician (if you have one):

Name:____ Phone: _________________________

Address:____

Please list any medical problems or conditions for which you are currently being treated:

____

____

____

Current medications (prescription, herbal, over-the-counter):

Name of Medication	Dosage	Frequency	Purpose	Prescribing Doctor

Please list any medications you have taken in the past that were prescribed to alleviate mental health symptoms:

____

____

____

Have you previously received any counseling, psychotherapy, or psychiatric care? YES/NO

Please describe (when, what kind, by whom):

____

____

____

Have you ever been hospitalized: YES/NO

Beginning Date:	End Date:	Reason:

Any history of suicide attempts: ______________ When? ________________

Describe:

____

____

____

Describe your level of physical activity:

____

____

____

Personal Information

Name 3 words to describe yourself: ______________________________

Name 3 words to describe your male parent figure(s):______________________________

Name 3 words to describe your female parent figure(s):______________________________

Name 3 words to describe your spouse/partner: ______________________________

Name 3 words to describe the family you grew up in: ______________________________

What is your sexual orientation?:__________________ What is your gender identity?:________________________

Who lives in your household with you currently (names, ages, relationship)?:

____

____

____

Briefly describe your level of social support/ friends:

____

____

____

Is spirituality/religion important in your life? YES/NO

If so, explain:

____

____

____

Please briefly describe any recent significant life events (ie; death in the family, loss of job, a recent move, etc):

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____

Have you ever been physically, emotionally, or sexually abused by anyone? Please briefly describe as much as you are comfortable sharing:

___

___

___

Describe any legal issues you had or currently have:

___

___

___

Do you smoke or use tobacco? YES/NO If YES, how much per day?:___________________

Do you smoke or use Cannabis? YES/NO If YES, how much per day?:___________________

Do you consume caffeine? YES/NO If YES, how much per day?:___________________

Do you drink alcohol? YES/NO If YES, how much per day/week/month/year?:__________________

Do you use non-prescription drugs? YES/NO If YES, what kinds and how often?:_________________________

Have any of your friends or family members voiced concerns about your substance/alcohol abuse? YES/NO

Have you ever been in trouble or risky situations because of your substance/alcohol abuse? YES/NO

Do you have thoughts or urges to harm others? YES/NO

If yes, please describe:

___

___

___

Have you experienced any traumatic events? YES/NO

Describe as much as you feel comfortable:

___

___

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Do you feel you have a healthy relationship w/food? YES/NO

Please Describe:

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Current Occupation:_________________________________ How long?:_________________________

Rate your level of employment satisfaction: 1 2 3 4 5 6 7 8 9 10

Do you have any hobbies or activities that you engage in for pleasure? Any sport(s)?: YES/NO

Please Describe:

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____

What diagnosis or condition, if any, that you know about do you think might apply to you?

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____

____

PLEASE CHECK ALL THAT APPLY:

DIFFICULTY WITH	NOW	PAST	DIFFICULTY WITH	NOW	PAST	DIFFICULTY WITH	NOW	PAST
Abandonment			Abdominal Distress/Issues			Abuse		
Affair			Alcohol			Allergies		
Alienation			Anger/Temper			Angina/Chest Pains		
Anorexia			Appetite			Asthma		
Aoidant			Binge Eating			Blended Family		
Body Image			Bonding			Boundaries		
Bulimia			Caffeine			Cancer		
Child Care			Children			Chronic Pain		
Chronic Fatigue			Codependency			Completing Tasks		
Diabetes			Delusions			Denial		
Depression			Disability			Disordered Eating		
Disorganized			Divorce			Domestic Violence		
Drugs			Easily Distracted			Elder Care		
Employment			Emptiness			Enabling		
Excessive Worry			Fainting/Dizziness			Family Conflict		
Fear			Finances			Frequent Fidgeting		
Friends			Gender Dysphoria			Getting to Sleep		

DIFFICULTY WITH	NOW	PAST	DIFFICULTY WITH	NOW	PAST	DIFFICULTY WITH	NOW	PAST
Grades			Grief			Guilt		
Head Injury			Heart Attack			Heart Palpitations		
History of Child Abuse			History of Sexual Abuse			HIV/AIDS		
Hormone-Related Problems			Hurting Yourself/Others			Hyperactivity		
Idealization			Inactivity			Inattention		
Inhibition			Impulsivity			Irritability		
Isolation			Jealousy			Learning Disabilities		
Legal Problems			Loss of Consciousness/ Blackouts			Making Careless Mistakes		
Mania/Feeling Manic			Marriage Partnership			Medical		
Memory Loss			Mood Swings			Muscle Tension		
Compulsions			Conduct			Crisis		
Obsessions			Oppositional			Nightmares		
"Nervous Breakdown"			Rage			Rationalization		
Self Absorption			Self Esteem			Separation Anxiety		
Somatization			Trust			Hallucinations		
Headaches			Pain			Panic		
Paying Attention			Parents			Rejection		
Relationships			Severe Weight Gain/Loss			Sexual Abuse		
Sexual Concerns			STD's			Speaking without Thinking		
Stress			Obesity			People in General		
Physical Abuse			Psychiatric Hospitalization			Resistance		
School Problems			Shame			Shortness of Breath		
Sibling Conflict			Social Skills			Sleep Problems		
Suicide			Trauma			Somatization		
Ruminative			Trust					

FAMILY HISTORY OF (check all that apply):

Drug/Alcohol Problems		Physical Abuse		Depression	
Legal Trouble		Sexual Abuse		Anxiety	
Domestic Violence		Hyperactivity		Psychiatric Hospitalization	
Suicide		Learning Disabilities		“Nervous Breakdown”	

What would you describe as a strength, talent, or virtue of yours?:

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Please add any additional information that you would like to include: