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CLIENT INFORMATION FORM

INSTRUCTIONS: *Please fill out the following information as completely as possible.*

Name _____ Home phone _____

Address _____ Work phone _____

_____ Best times to reach _____

Is it ok to leave a message at home? _____ At work? _____

Age _____ Birth date _____

Employment _____

Names of Children:

1. _____ Age _____ At home? _____

2. _____ Age _____ At home? _____

3. _____ Age _____ At home? _____

4. _____ Age _____ At home? _____

INSURANCE:

Provider Name _____ Plan # _____ Group # _____

Name of Primary Insured _____ SSN _____ Date of Birth _____

Reasons for seeking therapy?

Goals for therapy?

MINOR CLIENTS

If client is a minor, names of parents/legal guardians _____

Parents are: Unmarried Married Divorced Separated Other _____

Minor lives with: _____

Custody Arrangement _____

Please check the stressors, issues, areas of concern or events that apply or have applied to you in the past.

HEALTH: Surgery Sleep Illness Weight Eating Injury Drug or alcohol problems

In recovery Sexual difficulties Menopause Fatigue Other _____

LOSS: Death of a friend Death of a family member Abortion Miscarriage Other _____

TRAUMA: Accident Rape Domestic violence Abuse Other _____

LIFE CHANGE: Relocation New Family member Pregnancy Retirement Empty nest

Major change in income or life circumstance Other _____

SOCIAL: Friendships Isolation Other _____

LEGAL: Incarceration Arrest or conviction Lawsuit Custody/Visitation Probation

WORK/SCHOOL: School stress Job stress Promotion Job loss Career change

Other _____

FAMILY: Elderly Single parenting Parenting concerns Family conflict Family relationships

Other _____

RELATIONSHIPS: New relationship Divorce Separation Marriage Arguments Infidelity

Communication difficulties Substance abuse Other _____

EMOTIONAL: Self control problems Mood swings Suicidal thoughts Suicide attempt

Feelings of worthlessness Anxiety Compulsive thoughts or behaviors Anger Sadness

Aggression Confusion Fear Grief Other _____

What medications are you currently taking?

NAME DOSAGE FOR PRESCRIBED BY

1. _____

2. _____

3. _____

Substance Use. Please list the type of substance and average amount consumed or used each week.

Alcohol _____

Drugs (Prescription/Non-prescription) _____

Tobacco _____

Caffeine _____

Referred by _____

Emergency contact person (Name, Address, Phone, Relationship) _____
