Client Information

Date:_____

A. Identification Information

Name:_____ Date of Birth:_____ Age: _____

Address:_____ Apt.:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Employer /School:_____ Occupation / Studying: _____

B. Referral Information

Who gave you my name to call?_____

May I have your permission to thank this person for the referral? ❒ Yes ❒ No

C. Insurance Information

Your relationship to insured? ❒ Self ❒ Spouse ❒ Child ❒ Other

Insured's Name (if not Self) _____ Date of Birth:_____

Address _____

City_____State_____Zip_____ Phone:_____

Social Security # _____-_____-_____ Insurance ID # _____Policy Group #_____

Employer /School _____

Insurance Plan Name:_____

D. Family Information

Relationship Status: ❒ Single ❒ Married ❒ Partnered ❒ Divorced ❒ Widow / Widower

This is my ❒ 1st ❒ 2nd ❒ 3rd ❒ 4th marriage / partnership.

Number of children and their ages:_____

_____

_____

	First Name	*Current Age or Age at Death*	*Illness (Cause of Death)*	*Education*	*Occupation*
Father					
Mother					
Step Parent(s)					
Grandparents					
Uncles/Aunts					
Brothers					
Sisters					

Were your parents ❒ divorced ❒ never married ❒ still married ❒ widowed?

Where are you in the birth order of siblings in your family?_____

Family history of:

❒ Depression ❒ Suicide Attempts ❒ Anxiety

❒ Eating Disorders ❒ Mental Illness ❒ Violence

❒ Sexual Abuse ❒ Emotional Abuse ❒ Alcoholism / Drug Addiction

❒ Chronic Illness *(please explain)*_____

❒ Other _____

E. Medical Information

Primary Physician: _____ Last Exam: _____

Major (or chronic) Operations / Illnesses / Injuries _____

_____

_____

_____

Current Medications Dosage(s) Frequency Effectiveness Prescribing Physician

_____

_____

_____

Have you experienced any recent changes in:

❒ Sleep ❒ Nightmares ❒ Amount of Exercise

❒ Sexual Desire ❒ Eating /Appetite ❒ Weight

How would you characterize your overall health?

❒ Poor ❒ Fair ❒ Good ❒ Excellent

Do you smoke? ❒ Yes / ❒ No Did you smoke in the past? ❒ Yes / ❒ No

Packs Per Day _____ Beginning At What Age?_____ When did you quit? _____

Do you consume any alcohol? ❒ Yes / ❒ No

❒ Less than 1x / mo ❒ 1-3x / mo ❒ 1x / week

❒ Several x's / week ❒ Every day

❒ Beer ❒ Wine ❒ Hard Liquor (*check all that apply*)

Do you use any street drugs or misuse prescription drugs? ❒ Yes / ❒ No

Names of Drug(s): _____

Frequency of Use: _____

F. Treatment Information

Please describe the main concern(s) that have prompted you to see me now? _____

_____

_____

_____

_____

How have these concerns evolved over time?_____

_____

_____

_____

Please indicate your major life stressors of the past 12 months?

- ❒ Serious Illness or Injury
- ❒ Death of a Close Friend or Family Member
- ❒ Major Illness in Family
- ❒ Gain of New Family Member
- ❒ Divorce / Separation
- ❒ Job Change
- ❒ Other _____

Please describe what you would like to be different in your life when you are done with therapy?

_____

_____

_____

_____

Have you ever received psychological or psychiatric counseling before? ❒ Yes / ❒ No

When? From Whom? Purpose? Results?

_____

_____

_____

_____

_____

Have you ever been prescribed medication for a psychiatric or emotional problem? ❒ Yes / ❒ No

When? Prescribing Clinician? What Medication? For What? Results?

_____

_____

_____

_____

_____

Have you ever been hospitalized for a psychiatric or emotional health reason? ❒ Yes / ❒ No

When? Where? For What Reason? Outcome?

Have you ever been in a drug or alcohol treatment program? ❒ Yes / ❒ No

❒ Inpatient ❒ Outpatient

Where? How long? Outcome?

G. Social / Relationship Information

Please indicate any of the following that you have experienced?

❒ Death of Mother	Your age at occurrence____	
❒ Death of Father	Your age at occurrence ____	
❒ Death of Child	Your age at occurrence ____	Child's Age ____
❒ Death of Sibling	Your age at occurrence ____	Sibling's Age ____
❒ Desertion by mother as a child	Your age at occurrence ____	
❒ Desertion by father as a child	Your age at occurrence ____	
❒ Divorce of parents	Your age at occurrence ____	
❒ Sexual abuse	❒ Emotional abuse	❒ Physical abuse
❒ Violence in the family	❒ Mental Illness of a family member	

How do you get along with your present spouse or partner?

How do you get along with your children?

How do (did) you get along with your family of origin members?

Mother? _____

Father? _____

Siblings? _____

Please list the first names of your significant friends and indicate how long you have had these relationships?

First name How long? How often do you see this person?

_____

_____

_____

_____

H. Employment Information

What is the nature of your employment? _____

How long have you been employed in your current job? _____

How satisfied are you in this job?

❒ Not very satisfied ❒ Somewhat satisfied ❒ Comfortable ❒ Very satisfied

Are you satisfied that the income from your job adequately covers your living expenses?

❒ Not very satisfied ❒ Somewhat satisfied ❒ Comfortable ❒ Very satisfied

Do you have other sources of income? ❒ Yes / ❒ No

Please describe: _____

_____

I. Spiritual Resources

How significant a role does spirituality play in your life?

❒ None ❒ Somewhat important ❒ Significant ❒ Very significant

J. Other

Is there anything else you think I should know about prior to our beginning your treatment?

_____

_____

_____