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Therapy for individuals and couples
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Client Information Form

Today's date: _____

Client's name: _____ Date of birth: _____ Age: _____

Nicknames or aliases: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Secondary Phone: _____
(❑ Mobile ❑ Home ❑ Other) (❑ Mobile ❑ Home ❑ Other)

E-mail: _____

Calls or e-mails will be discreet, but please indicate any restrictions: _____

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

Emergency information: If an emergency arises and I cannot reach you directly, or I need to reach someone close to you, whom should I call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Referral: Who gave you my name to call?

Name: _____

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

Education/Career:

Highest level of education, and field of study if applicable: _____

If currently attending school, school name and area of study: _____

Employer: _____ Occupation: _____

Current Marital/Relationship Status (✓all that apply)**:**

❑ Single ❑ Married ❑ Living with Partner ❑ Separated ❑ Divorced ❑ Widowed

If applicable: Spouse/partner's name:_____ Age: _____

Spouse/partner's occupation: _____ In this relationship for how long? _____

<u>Other</u> Significant Relationship History:

	Spouse/partner's name	Your age when relationship began	Length of relationship	Did you marry? (Y/N)	Did you divorce (D) or were you widowed (W)?	Has spouse/ partner remarried?
First						
Second						
Third						

Religious/spiritual preference: _____ Involvement: ❑ None ❑ Some/Irregular ❑ Active

How important are spiritual concerns in your life? _____ Scale: 1 (not important) - 10 (central to my life)

Ethnicity/national origin: _____

Any other way you identify yourself and consider important: _____

Family-of-Origin and Current Family:

Relative	First Name	Current Age (or age at death, <u>and</u> circle)	List any significant illnesses (or cause of death, if deceased), including mental illnesses	Live with you?
Mother				
Father				
Step-mother				
Step-father				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

Relative	First name	Current age (or age at death, and circle)	Illnesses (or cause of death, if deceased), including mental illnesses	Live with you?
Child or Step- child				
Child or Step- child				
Child or Step- child				
Child or Step- child				
Child or Step- child				
Child or Step- child				
Other				
Other				

Health and Medical Care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ❑ Yes ❑ No

Date of your last physical: _____ Are you generally healthy? ❑ Yes ❑ No

If no, explain: _____

Do you generally sleep well? ❑ Yes ❑ No If no, explain: _____

_____

Typical number of hours you sleep each night: _____

Do you eat well-balanced meals regularly? ❑ Yes ❑ No Do you exercise regularly? ❑ Yes ❑ No

Amount of alcohol intake per week: _____

Type and amount of recreational or other drug use per week: _____

Current medical conditions or concerns: _____

_____

History of major illnesses or injuries (with approximate dates): _____

_____

_____

Current medications (include both prescription and over-the-counter):

Name	Dosage	Purpose

Have you received counseling or therapy before? ❑ Yes ❑ No If yes, please indicate:

When?	From whom?	For what?	With what results?

What was most useful from your prior therapeutic experiences? _____

_____

_____

_____

_____

What was least useful from your prior therapeutic experiences? _____

_____

_____

_____

Have you ever taken medications for psychiatric or emotional problems? ❑ Yes ❑ No If yes, please indicate (You do not need to list medications you are currently taking, listed on previous page):

When?	From whom?	Which medications?	For what?	With what results?

Is there any other information you would like me to know? _____