Client Information Form

Please note: Information you provide here is protected as confidential information.
Client's Name:

Date:

Name of parent/ guardian (if under 18 years of age):

Birth Date: _____ / _____ / _____ Age: _____
Gender: ☐ Male ☐ Female ☐ Trans Ethnicity / Race: _____
Current Address:
(Street and Number) _____
(City) (State) (Zip) _____

Best Phone Contact: _____ May we leave a message? ☐ Yes ☐ No
E-mail: _____ May we e-mail you? ☐ Yes ☐ No
Please note: Email correspondence is not considered to be a confidential medium of communication.

Two people to contact in case of emergency:

Name: _____	Name: _____
Phone:_____	Phone:_____
Relationship:_____	Relationship:_____

How did you hear about us? Ad ___Friend or Family Member ___ Other _____

Let's Talk About You:

1. Do you consider yourself to be spiritual or religions? ☐ No ☐ Yes
2. Are there any ethnic or cultural practices or beliefs, which we need to be aware of? ☐ No☐ Yes
If yes, please describe: _____
3. Please list your hobbies and interests: _____
_____
4. Do you have a pet? ☐ No ☐ Yes If yes what type _____
5. What would you like to accomplish out of your time in counseling services?
_____
_____
_____
6. What are some of the issues / problems that have led to you seek counseling services at this time?
_____

GENERAL AND MENTAL HEALTH INFORMATION:
Have you previously received any type of mental health or addiction services (psychotherapy, psychiatric services, etc.)?
☐ No ☐ Yes, previous therapist/ practitioner: _____
Are you currently taking prescription medication? ☐ Yes ☐ No Please list:
_____
Have you ever been prescribed psychiatric medication? ☐ Yes ☐ No Please list and provide dates:
_____
Please list any known Allergies: _____
Who is your Primary Care Physician: _____

- How would your rate your current physical health? (please circle)
  Poor Unsatisfactory Satisfactory Good Very Good
- Please list any specific problems you are experiencing:
  _____
- How would you rate your current sleeping habits? (please circle)
  Poor Unsatisfactory Satisfactory Good Very Good
- Please list any specific problems you are experiencing:
  _____
- Do you exercise? _____ Types of exercise _____
- Please any difficulties you experience with your appetite or eating patterns:
  _____
- Are you currently experiencing overwhelming sadness, grief, or depression? ☐ No ☐ Yes
  If Yes, for approximately how long? _____
- Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐ No ☐ Yes
  If Yes, when did you begin experiencing this? _____
- Are and/or have you ever thought about suicide? ☐ No ☐ Yes
  If Yes, how long ago? _____

- What significant life changes or stressful events have you experienced recently:

_____

FAMILY MENTAL HEALTH HISTORY:
In this 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.):
Alcohol / Substance Abuse Anxiety Depression Domestic Violence
Eating Disorders Obesity Obsessive Compulsive Behavior Schizophrenia Suicide Attempts