

## CLIENT INFORMATION FORM

*Please note that this information is confidential. It is for my use only and I will not disclose anything on this form to anyone else without your written consent on a "Release of Information" form.*

Date: \_\_\_\_\_

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip code \_\_\_\_\_

Phone numbers:

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

(please circle preferred contact phone number)

May I leave a message at your preferred contact phone number?

Yes \_\_\_\_\_ No \_\_\_\_\_

Any restrictions on messages I can leave at that number?

E-mail address \_\_\_\_\_

Emergency contact name \_\_\_\_\_ Phone(s) \_\_\_\_\_

Partnered/married? Circle one: Yes No If yes, how long? \_\_\_\_\_

Children? Yes No If yes, please list name(s), gender(s) and age(s)

Others in household?

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_ Relationship \_\_\_\_\_

Occupation or former occupation (indicate which): \_\_\_\_\_

Full-time or part-time? (circle one) # of years you have worked in this occupation: \_\_\_\_\_

Current employer, if any: \_\_\_\_\_

If unemployed, are you looking for work? Yes No (circle one)

Will you be paying for my services yourself, or are you hoping to use insurance? (circle one)

Insured's name (if not you) \_\_\_\_\_ Date of birth: \_\_\_\_\_

Insured's employer \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

Have you been in counseling or therapy before? Yes No

If yes, was it individual, group, couples, or family? \_\_\_\_\_

Approx. dates: \_\_\_\_\_ Length of time: \_\_\_\_\_ Type of therapy: \_\_\_\_\_

Reasons for seeking counseling or therapy at that time:

Please briefly explain why you are seeking counseling or therapy at this time:

Do you have any reservations about counseling/therapy? If yes, please explain.

What strategies, if any, do you have for handling stress, anxiety, and depression?

How would you describe your physical health at present?  
In the past?

Do you have any chronic physical problems or recent health issues? If yes, please give specifics:

Primary Care Provider: \_\_\_\_\_ at \_\_\_\_\_

Approximate date of most recent physical exam: \_\_\_\_\_

What were the results of this exam?

Are you taking or have you taken medication for depression, anxiety, or other mental health issues?

Yes No If yes, list medication, dosage, and approximate dates:

Have you ever been hospitalized for psychiatric reasons? Yes No

If yes, approx. dates: \_\_\_\_\_ Length of time: \_\_\_\_\_

Reasons for hospitalization:

Have you or has anyone in your family ever attempted suicide? Yes No If yes, please give dates and circumstances:

Is there any substance abuse (alcohol or drugs) or violence (current or in the past) in your family of origin or current family?

Yes No (circle one) If yes, please give specifics:

Is there any history of mental health disorders in your family of origin or current family?

Yes No (circle one) If yes, please give specifics:

How often, and what, do you eat on a typical day? Please be specific.

Please describe your use (past and present) of alcohol and other non-prescription drugs, including nicotine:

Please describe your typical intake of caffeine and sugar:

Please describe your typical night's sleep:

Do you exercise regularly? If yes, please give specifics, including type, length, and frequency:

Is there anything else you'd like me to know about you in advance?

Is there anything you'd like to ask about therapy, about me, or about my therapy practice in advance?

***Please sign to indicate that the information you have given me is accurate to the best of your knowledge and that you understand it is confidential.***

**Your**  
**signature** \_\_\_\_\_ **Date** \_\_\_\_\_