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# CLIENT INFORMATION

## 1. IDENTIFYING INFORMATION

Name: ________________________________________ Date: ____________

Address: ______________________________________ City, State, Zip __________________________

Telephone(s) ________________ ________________ ________________ ________________
(Home) (Work) (Cell) (Other)

May I leave messages at home? *Circle* Yes or No. At work? Yes or No. At Cell + "Other"? Yes or No

Your email address: ________________________ May we communicate through email?: *circle* Yes or No?

Gender: M____ F____ ____ Age: _____ Birthdate: ________________

Your Ethnicity/Cultural Identification(s): ______________________________________________________

Marital Status: ________________ Spouse/Partner (if any): ___________________________

Your Sexual/Affectional Orientation/Identity: ____________________________________________________

Education: Self: ______________________________ Spouse/Partner's: _____________________________

Occupation: _________________________________ Spouse/Partner's: _____________________________

Employer: __________________________________ Spouse/Partner work phone: ___________________

Who referred you to me? _________________________________

Emergency Contact: ___________________________ Phone(s): ________________ __________________
(Home) (Work or Cell)

Relationship to Emergency Contact: ______________________________________________________________

| Family Members Names | Relationship | Age | Occupation/School | Lives with You? |
|---|---|---|---|---|
| ____________________ | _____________ | ____ | _________________ | ____________ |
| ____________________ | _____________ | ____ | _________________ | ____________ |
| ____________________ | _____________ | ____ | _________________ | ____________ |
| ____________________ | _____________ | ____ | _________________ | ____________ |

## 2. Please Describe the Primary Problem(s) for Which You are Seeking Therapy at This Time:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please check any of the symptoms that you are having or have had very recently:

___ Depression
___ Feeling hopeless
___ Extreme sadness
___ Trouble concentrating
___ Change in sleeping habits
___ Feeling helpless
___ Change in eating habits
___ Weight changes
___ Memory problems
___ Trouble performing your job
___ Lack of energy
___ Acting violently
___ Obsessions or compulsions
___ Self-esteem problem
___ Change in sexual interest or function
___ Physical complaints of pain
___ Easily irritated
___ Concern about sexual orientation
___ Thoughts about hurting yourself
___ Feeling nervous
___ Feeling guilty
___ Thoughts about hurting others
___ Muscle tension
___ Feeling of extreme happiness
___ Thoughts about killing yourself
___ Sudden feelings of panic
___ Lack of enjoyment of usual activities
___ Thoughts about killing others
___ Problems with anger
___ Perfectionism
___ Problems getting along with family/others
___ Feeling stressed

___Other:____________________________________________________________

______________________________________________________________________

**3. PREVIOUS MENTAL HEALTH TREATMENT**

A. Please tell me about your previous therapists, if any: ____ Check here if none.

| Name | Dates of Treatment | Reason for Treatment | Outcome |
|---|---|---|---|
| | | | |
| | | | |

B. Please tell me about any psychiatric hospitalizations: ____ Check here if none.

______________________________________________________________________

______________________________________________________________________

**4. MEDICAL INFORMATION**

Your Primary Physician: ______________________________ Phone: ________________

Other Treating Physicians/Nurse Practitioner: _________________________ Phone: ________________

_________________________ Phone: ________________

Please list current medical conditions:

1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________

Please list any allergies:

1. ____________________________________________________________
2. ____________________________________________________________

Current Medications:

| | Name | Dosage/Day | Condition Treating | Who Prescribing | How long have you taken? |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |

Indicate problems or conditions you have currently (use "**C**") or have had in the past (use "**P**"):

___ Headache
___ Faintness
___ Dizziness
___ Sleep problems
___ Muscle/joint/bone
___ Weakness
___ Numbness
___ Urinary
___ Appetite problems
___ Stomach/bowel
___ Chest pain
___ Eye, ear, nose, throat
___ Skin
___ Genital
___ AIDS
___ Alcoholism
___ Appendicitis
___ Arthritis
___ Asthma
___ Cancer
___ Chemical dependence
___ Chicken pox
___ Diabetes
___ Epilepsy
___ Heart disease
___ Hepatitis
___ High cholesterol
___ HIV positive
___ Kidney disease
___ Liver disease
___ Measles
___ Multiple sclerosis
___ Mumps
___ Prostate problem
___ Rheumatic fever
___ Scarlet fever
___ Stroke
___ Thyroid problems
___ Tonsilitis
___ Tuberculosis
___ Ulcers
___ Venereal disease

When was your last complete physical exam? ________________________

Please list any major hospitalizations, with dates and condition treated:

1. ________________________________________________

2. ________________________________________________

## 5. EXERCISE:

Do you exercise and /or play a sport regularly? If so, describe what and how often: ______________________

________________________________________________________________

## 6. SUBSTANCE USE HISTORY

Please indicate if you currently use or have used in the past the following substances:

| | Past | Current | Amount |
|---|---|---|---|
| Tobacco/cigarettes | ____ | ____ | _______ |
| Alcohol | ____ | ____ | _______ |
| Caffeine (includes coffee, colas etc.) | ____ | ____ | _______ |
| Marijuana | ____ | ____ | _______ |
| Tranquilizers | ____ | ____ | _______ |
| Pain killers | ____ | ____ | _______ |
| Over-the-Counter meds | ____ | ____ | _______ |
| Prescription meds | ____ | ____ | _______ |

Other (specify) ______________________________

| | Past | Current | Amount |
|---|---|---|---|
| Cocaine | ____ | ____ | _______ |
| Mushrooms | ____ | ____ | _______ |
| LSD | ____ | ____ | _______ |
| Psychedelics | ____ | ____ | _______ |
| Sleeping pills | ____ | ____ | _______ |
| Crank/crack | ____ | ____ | _______ |
| Amphetamines | ____ | ____ | _______ |
| Inhalants (e.g. gas, glue etc.) | ____ | ____ | _______ |

Do you now use or have you in the past used any of the above substances excessively? If so, please list time period and amounts of excessive use:

________________________________________________________________________________

________________________________________________________________________________

Please list any past or current facilities for substance abuse treatment (specify dates):

1. ____________________________________________________________________
2. ____________________________________________________________________

**7. OTHER HISTORY**

A) Education

___ Less than 12 years (specify highest grade completed ______________
___ High School
___ College (# of years completed if no degree) ______________________
___ Master's Degree (specify) ____________________________________
___ Doctoral Degree (specify) ____________________________________

Did you receive special education? ____ Yes ____ No Learning Disability? ____ Yes ____No

B) Occupation: Please list past job titles and dates

1. ____________________________________________________________________
2. ____________________________________________________________________
3. ____________________________________________________________________
4. ____________________________________________________________________

C) Family Psychiatric History

Please tell me about any family psychiatric history, including diagnoses and hospitalizations if you know them:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

- THANK YOU FOR THE TIME AND EFFORT TO FILL THIS OUT -

(Revised 7/11)