

CLIENT INFORMATION FORM

Date: _____

Gender: Male Female

Name: _____

Phone: _(_____)_____-_____

Address: _____

CITY

STATE

ZIP

Client's SS# : _____-_____-_____

DOB: _____

AGE: _____

Marital Status: _____

Who referred you here? _____

Employer: _____

Hourly Salaried Full-Time Part-Time Temp.

Shift: _____to_____ Hours per week worked? _____ How long have you worked there? _____

Any problems with: Supervisor Co-worker Absenteeism Tardiness Other: _____

Highest Grade Completed: G.E.D. High School College years completed: _____ Degree: _____

Were there any problems in school? Yes No Special skills or training: _____

Are you a veteran? Yes No Branch of Service: _____ Any combat time? Yes No

Your Emergency Contact Person: _____ Relationship to you: _____

Their Phone Number: _____

Briefly explain what problem brings you in today: _____

Specifically, what have you done to make this situation or problem better: _____

When did this situation or problem begin?

1 day ago 1 week ago 2-3 weeks ago 1 month ago _____ months ago 1 year ago Longer

Name: _____

Date: _____

RECENT STRESSFUL LIFE EVENTS

Check any of the following that have occurred in the last two years:

	Marital Stressors		Legal Difficulties
	Sexual Difficulties/Sexuality Issues		Financial Difficulties
	Difficulties with Family Members		Breakup of an Important Relationship
	Personal &/or Family Illness or Injury		Difficulties at Work &/or School
	Violence		Death of a Loved One
	Lost Job, Job Promotion, Retired		Child Left Home
	Changed Residence		Spirituality Issues

CURRENT FAMILY

Who lives in your home?

Names	Ages	Relationship to You

NAME OF CURRENT SPOUSE/PARTNER: _____ Number of Children: _____

Number of Years Married/Together: _____ How Long Separated: _____ Is Divorce Pending: _____

NAME OF PAST SPOUSE/PARTNER: _____ Number of Children: _____

Number of Years Together: _____ How long have you been Divorced: _____

Number of Significant/Serious Relationships: _____

FAMILY OF ORIGIN

Name	Age	City	Occupation
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Your Father: _____

Your Mother: _____

Are these your Birth Parents? Yes No

Name: _____

Date: _____

FAMILY OF ORIGIN (continued)

Name

Age

City

Occupation

Your Stepfather: _____

Your Stepmother: _____

Your (Birth, Half, and Step) Siblings: _____

PRESENTING SYMPTOMS AND SEVERITY

Please identify the severity of each symptom that applies to you, and for those that do not apply to you leave them blank. Please use the rating system for those symptoms that do apply to you:

1 = Mild Severity 2 = Moderate Severity 3 = High Severity 4 = Extremely High Severity

Persistent Sadness		Irritability or Grouchy	
Worry or Fretting		Crying	
Pessimism or Negative Outlook		Energy Loss	
Insomnia		Sleeping A Lot	
Feeling Harassed &/or Persecuted		Indecisive	
Memory Problems &/or Poor Concentration		Appetite Problems / Up or Down Weight	
Waking Up Early		Lack of Interest in Activities Once Enjoyed	
Lowered Libido or No Interests in Sex		Grief &/or A Deep Sense Of Loss	
Racing Thoughts (especially before sleep)		Pulling Away From Others or Isolating	

Do you fear losing anymore day-today functioning than you have already loss? Yes No

SELF – HARM POTENTIAL

Have you ever seriously thought about harming yourself? Yes No

Have you ever attempted suicide? Yes No

Are you having thoughts about harming yourself now? Yes No

HARM TO OTHERS

Have you ever seriously thought about hurting someone else? Yes No

Have you ever intentionally hurt someone else? Yes No

Are you thinking about hurting someone now? Yes No

Have you ever been hospitalized for any mental health or substance abuse problem? Yes No

Have you ever seen a psychotherapist before? Yes No

Was it helpful? Yes No

Where and when did you receive these services: _____

Name: _____

Date: _____

MEDICAL HISTORY

Your Physician: _____ Last seen & for what: _____

Medications	Dosage	Times Per Day	Condition being Treated

Do you have or have you ever had or ever had any of the following: C = Current P = Past

Anemia	Syphilis	Gonorrhea	Herpes
Cancer	Hepatitis	Glaucoma	Gout
Arthritis	Cirrhosis	Heart Disease	Chest Pains
Hypoglycemia	Diabetes	Ulcers	High Blood Pressure
Kidney Disease	Epilepsy	Liver Disease	Bladder Trouble
Head Injury	Asthma	Stroke	Seizures
Emphysema	PMS	Blackouts	Fast Heart Beat
Dizziness	Nosebleeds	Nervousness	Blurred Vision
Diarrhea	Constipation	Crying Spells	Sleep Problems
No Appetite	Difficulty Hearing	Stomach Pains	Headaches
Vomiting	Numbness	Food Cravings	Hearing Voices
Weight Gain	Weight Loss	Use Of Nicotine	Sexual Problems
Pregnancies & Number	Currently Pregnant	Frequent Sore Throat & Coughing	Irregular Menstrual Cycle
Difficulty Remembering	Excessive Use Of Caffeine	Use Of Weight Control or Sleep Medications	Use of "Street" Drugs
Excessive Use Of Alcohol	Chronic Pain	Irritable Bowel Syndrome	Neurological Numbness

If you use or have used please endorse the following:

Substance	First Use	How Used	Your Past Use		Your Current Use		Last Used
			How Much	How Often	How Much	How Often	
Tobacco							
Alcohol							
Cannabis							
Cocaine							
Prescriptions Misuse							
Opiates							
Other							

Name: _____

Date: _____

FINANCIAL

Check all that applies to you:

Wages Garnished		Driver's License Suspended	
Bankruptcy		Pending Legal Problems	
Repossession of Car, House, etc.		Debt Turned Over to Collection Agency	

LEGAL

Please indicate the date you were arrested for any of the below charges:

Reckless Driving		OUIL/DWI/DUI/ Impaired	
Hit and Run		Sales or Trafficking	
Possession		Breaking and Entry	
Domestic Violence		Property Damage	
Vagrancy		Disorderly Conduct	
Public Intoxication		Other	

If you have been arrested for a Felony, tell me when and what for: _____

The longest period you have been incarcerated has been: _____

SPECIAL INFORMATION: If there is any special information you want me to know about you?
