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CLIENT INFORMATION FORM

YOUR PERSONAL DATA

Name ______________________________	Date ______________________________
Address ______________________________	Age ______ DOB ____/____/____ Sex M F
______________________________	Home Phone (_____) ____________________
______________________________	Cell Phone (_____)____________________
______________________________	Occupation ______________________________
Email Address ______________________________	Employer ______________________________
I may be contacted via ___ Email ___ Text ___ Voicemail	Work Phone (_____)____________________
Insurance Plan ______________________________	Referred by ______________________________
Insurance ID ______________________________	Referral Phone (_____)____________________
Insurance Phone ______________________________	Marital Status ______________________________
Emergency Contact ______________________________	Phone (_____)____________________
Address ______________________________	Relation to you ______________________________

Briefly describe what motivated you to seek therapy at this time (rather than some time earlier or later). Please include any particular events or changes in circumstances which triggered your decision to seek treatment:

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CHIEF CONCERNS: Please list the major difficulties that you would like help with in therapy, how long these problems have lasted, and rate the severity of each one according to the scale below:

Not a Problem Mild Problem Moderate Problem Severe Problem Couldn't be worse

0--------1--------2--------3--------4--------5--------6--------7--------8--------9--------10

	Duration	Rating
1. ____	____________	_____
2. ____	____________	_____
3. ____	____________	_____

Please rate (from 1-10) how much your difficulties are affecting the following areas of your life:

____ Marriage/Relationship	____ Family	____ Friendships
____ Job/School	____ Financial	____ Legal
____ Mood	____ Anxiety/Nerves	____ Temper/Patience
____ Physical Health	____ Eating Habits	____ Sleeping Habits
____ Concentration	____ Sexual Functioning	____ Alcohol/Drug Usage

SELF-ASSESSMENT OF FUNCTIONING:

How are you coping with these problems? ______________________________

What do you do to make yourself feel better? ______________________________

Which hobbies and interests do you still enjoy? ______________________________

Do you have someone who is supportive and whom you can confide in during difficult times? No Yes

PRIOR TREATMENT: Have you received mental health or substance abuse counseling before? No Yes

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

Have you ever been hospitalized for mental health issues in the past? No Yes

If yes, for what purpose(s)? ______________________________

Have you ever taken medications for psychiatric or emotional problems? No Yes

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

Is there a family history of: Alcohol/drug problems ___ Psychological problems _____ Other problems _____

____

YOUR MEDICAL CARE: Do you have any medical conditions I should be aware of? No Yes

____

____

How would you rate your overall health? ___Excellent ___ Good ___ Fair ___Poor

Do you exercise? No Yes What is your routine? ______________________________

Have you ever been hospitalized for a physical condition? No Yes

If yes, what and for how long? ______________________________

Please list any medications you are taking:______________________________

In the past year, how many: Visits to doctor____ Sick days____ Cigarettes-day ____ Alcoholic drinks/day _

How do you think I might be of help to you? ______________________________

____

What results to you expect from treatment? ______________________________

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