Client Information Form

Today's date: _____

A. General Information

Name: _____ Date of Birth: _____ Age: _____

Current Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Work:_____Cell:_____

Email: _____

May we call you at home? ☐ Yes ☐ No May we leave a message at home? ☐ Yes ☐ No

May we call your cell? ☐ Yes ☐ No May we leave a message on cell? ☐ Yes ☐ No

May we text your cell? ☐ Yes ☐ No

May we email you? ☐ Yes ☐ No

Best number to reach you directly: _____

Emergency Contact Name:_____ Phone: _____

Relationship to you: _____

Employer:_____

How long at present job? _____

Whom may we thank for referring you?_____

How did this person explain that I might be of help to you? _____

_____

B. Family Information

Marital Status: _____ Spouse's Name: _____ Spouse's Age: _____

Spouse's Occupation: _____ Years Married: _____

Previous Marriages: ☐ Yes ☐ No If yes, how many times have you been married? _____

Children's Names	Age	Sex	Relation	At Home?

Were your parents: ☐ Divorced ☐ Never Married ☐ Still Married ☐ Widowed

Names and ages of your siblings: _____

_____

Where were you in the birth order of siblings in your family? _____

Family History of:

☐ Depression ☐ Suicide Attempts ☐ Anxiety ☐ Eating Disorders

☐ Mental Illness ☐ Violence ☐ Sexual Abuse ☐ Emotional Abuse

☐ Alcoholism / Drug Addiction ☐ Sexual Addiction

☐ Chronic Illness (please explain): _____

☐ Other: _____

Please indicate any of the following that you have experienced:

☐ Death of Mother	Your age at occurrence _____	
☐ Death of Father	Your age at occurrence _____	
☐ Death of Child	Your age at occurrence _____	
☐ Death of Sibling	Your age at occurrence _____	
☐ Desertion by mother as a child	Your age at occurrence _____	
☐ Desertion by father as a child	Your age at occurrence _____	
☐ Divorce of parents	Your age at occurrence _____	
☐ Sexual abuse	Your age at occurrence _____	By Whom? _____
☐ Physical abuse	Your age at occurrence _____	By Whom? _____
☐ Violence in the family	Your age at occurrence _____	By Whom? _____
☐ Mental illness of a family member	Your age at occurrence _____	Which member? _____

C. Medical Information

Primary Physician: _____ Phone: _____

Major (or Chronic) Illnesses/Operations/Injuries: _____

_____

Current Medications: _____

Have you experienced any recent changes in: ☐ Sleep ☐ Nightmares ☐ Amount of Exercise ☐ Sexual Desire ☐ Eating/Appetite ☐ Weight ☐ Alcohol Intake ☐ Stamina ☐ Energy

How would you characterize your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Chemical Use:

1. Have you ever felt the need to cut down on your drinking? ☐ No ☐ Yes
2. Have you ever felt annoyed by criticism of your drinking? ☐ No ☐ Yes
3. Have you ever felt guilty about your drinking? ☐ No ☐ Yes
4. Have you ever taken a morning "eye-opener"? ☐ No ☐ Yes
5. How much beer, wine, or hard liquor do you consume each week, on the average? _____
6. How much tobacco do you smoke or chew each week? _____
7. Which drugs (not medications prescribed for you) have you used in the last 10 years?

   _____

   Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects, and so forth:_____

   _____
8. Have you ever been in a drug or alcohol treatment program? ☐ No ☐ Yes

D. Treatment Information

Have you ever received psychological counseling or psychiatric counseling before? ☐ Yes ☐ No

Counselor's Name: _____

Reason for past counseling: _____

_____

Please describe the main difficulty that has brought you to see me: _____

_____

_____

_____

Indicate the severity of your problems on the scale below:

☐ Mild ☐ Moderate ☐ Severe ☐ Extremely Severe ☐Incapacitating

Please indicate the major stressors in your life in the last twelve months:

☐ Serious injury/illness ☐ Death of a close friend or relative ☐ Major illness in family

☐ Divorce/Separation ☐ Job Change ☐ Gain of a new family member

☐ Other (please describe):_____

Please describe what you would like to be different in your life when you are done with treatment:_____

_____

_____

Have you ever thought about suicide? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No If yes, when? _____

Are you required by a court, the police, or a probation/parole officer to have this appointment?
☐ No ☐ Yes If yes, please explain: _____

E. Other

Is there anything else that is important for me to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:

_____

_____

_____

Client Signature: _____

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