Client Information Form

The requested information will become part of your file and d is limited to the guidelines of confidentiality.

A. Identification

Name: _____

Date of Birth: _____ **Age:** _____

Social Security Number (used for insurance filing only): _____

Address: _____

_____

City State Zip Code

May I have permission to mail to this address? Yes _____ No _____

Phone Numbers	**May I call you at this number?**		**Leave a message?**	
(H) _____	**Yes** _____	**No** _____	**Yes** _____	**No**
(W) _____	**Yes** _____	**No** _____	**Yes** _____	**No**
(Mobile) _____	**Yes** _____	**No** _____	**Yes** _____	**No**

Email address: _____

May I have permission to email to this address? Yes _____ No _____

Place of Work: _____

Occupation: _____

B. Emergency Information:

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you whom should we call?

Name: _____ **Phone:** _____

Address: _____

City State Zip Code

Your relationship to this person:_____

C. Referral: Who gave you my name to call?

Name: _____

May I have your permission to thank this person for the referral?

Yes ___ No _____

D. Your Medical Care: From whom or where do you get your medical care?

Clinic/doctor's name:_____ **Phone:** _____

If you enter treatment with me for psychological problems, May I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment?

Yes __ No _____

E. Background Information

Are you currently on any prescribed medications? Yes No

If yes, what kind?

Do you drink alcohol? Yes No

If yes, how often? _____

Do you use drugs? Yes No

If yes, how often? _____

Were there any significant childhood illnesses or events? _____

_____

_____

Have you ever felt suicidal? _____

Have you sought counseling before? **Yes** **No**

With whom? _____

Please use a few words to describe your mother: _____

_____

Please use a few words to describe your father: _____

_____

How do you think your mother would describe you? _____

_____

How do you think your father would describe you? _____

_____

Name/Age of Siblings: _____

_____

_____

_____

Name/Age of Children: _____

_____

_____

_____

Is there anything else I will need to know but have not asked? _____

_____

_____

Please circle all those that apply:

Anger	Finances	Crisis	Marital	Family
Childrearing	Adolescence	Future Debts	School	Career
Retirement	Divorce	Boss	Separation	Stealing
Past	Dreams	Health	Personality	Lying
Nutrition	Sex	Parents	Weight	Pain
Emotional	Job	Anxiety	Drugs	Worries
Obsessions	Fear	Alcohol	Grief	Spouse
Relationship	Death	Headaches	Incest	Father
Mother	Body Image	Hostility	Brother	Sister
Recent Loss	Bed-wetting	Health	Learning Difference	
Developmental Issues	Apathy	In-Laws	Divorce	Children
Suicide	Sleep Disturbances	Homosexuality	Childhood Neglect	
Abuse	Personal Growth	Adoption	Control Issues	
Panic Attacks	Molestation	Pregnancy	Abortion	
Miscarriage	Chronic Pain	Depression	Post-partum	
Medication	Legal Issues			

I'm most afraid of: _____

_____

_____

What do you hope to gain from counseling? _____

_____

_____

_____