Client Information

Date: _____

A. Identification Information

Name: _____ Date of Birth:_____ Social Security # _____

Address: _____ Apt.:_____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Employer/School: _____ Occupation/Study: _____

B. Referral Information

Who gave you my name to call? _____

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

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C. Insurance Information

Your relationship to the insured? ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name (if not self) _____ Date of Birth: _____ Social Security # _____

Address: _____ Apt.:_____ Home Phone: _____

City: _____ State: _____ Zip: _____ Employer: _____

Insurance ID#: _____ Policy Group # _____ Insurance Plan Name:_____

D. Family Information

Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Widow/Widower

This is my ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th marriage/partnership.

Number of children and their ages: _____

_____

Were your parents ☐ Divorced ☐ never married ☐ still married ☐ widowed?

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

Family History of:

☐ Depression ☐ Suicide ☐ Anxiety
☐ Eating Disorder ☐ Mental Illness ☐ Violence
☐ Sexual Abuse ☐ Emotional Abuse ☐ Alcoholism/Drug Addiction

☐ Chronic Illness (please explain): _____

☐ Other: _____

_____

Client Information

	First Name	Current Age or Age at Death	Illness (Cause of Death)	High Level of Education Earned	Occupation
Father					
Mother					
Step Parent(S)					
Grandparents					
Uncles/Aunts					
Brothers					
Sisters					

E. Medical Information

Primary Physician:_____ Phone: _____ Last Exam: _____

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

_____

_____

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

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

Do you smoke? ☐ Yes ☐ No Smoke in the past? ☐ Yes ☐ No Packs/Day _____ Began at what age? _____ When did you quit _____

Do you consume any alcohol? ☐ Yes ☐ No ☐ Less than 1x / mo. ☐ 1-3x / mo. ☐ 1x / week ☐ Several x's / week ☐ Every Day

☐ Beer ☐ Wine ☐ Hard Liquor (check all that apply)

Do you use any street drugs or misuse prescription drugs? ☐ Yes ☐ No

Indicate name of drug(s) and frequency of Use: _____

_____

_____

Client Information

F. Treatment Information

Please describe the main concern(s) that have prompted you to see me now? _____

_____

_____

How have these concerns evolved over time? _____

_____

_____

Please indicate your major life stressors of the past 12 months?

☐ Serious Illness or injury ☐ Death of close friend or family member ☐ Major Illness in Family

☐ Gain of New Family Member ☐ Divorce / Separation ☐ Job Change

☐ Other: _____

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

_____

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

When? From Whom? Purpose? Results?

_____

_____

_____

Have you ever been hospitalized for a psychiatric or emotional problem? ☐ Yes ☐ No

When? Where? Purpose? Results?

_____

_____

_____

Have you ever been prescribed medication for a psychiatric or emotional problem? ☐ Yes ☐ No

When? Prescribing Clinician? What Medication? For What? Result?

_____

_____

Have you ever been in a drug or alcohol treatment program? ☐ Yes ☐ No ☐ Inpatient ☐ Outpatient

When? Prescribing Clinician? What Medication? For What? Result?

_____

_____

Client Information

G. Social/Relationship Information

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 _____ Child's Age _____
- ☐ Death of Sibling — Your age at occurrence _____ Sibling's Age _____
- ☐ Desertion of mother as a child — Your age at occurrence _____
- ☐ Desertion of father as a child — Your age at occurrence _____
- ☐ Divorce of parents — Your age at occurrence _____
- ☐ Sexual abuse — ☐ Emotional Abuse ☐ Physical abuse
- ☐ Violence in the family — ☐ Mental illness of a family member

How do you get along with your present spouse or partner? _____

_____

How do you get along with your children? _____

_____

How do (did) you get along with your family of origin members?

Mother? _____

Father? _____

Siblings? _____

Please list the first names of your significant friends and indicate how long you have had these relationships?

First Name How Long? How often do you see this person?

_____

_____

_____

H. Employment Information

What is the nature of your employment? _____

How satisfied are you in this job? ☐ not very satisfied ☐ somewhat satisfied ☐ Comfortable ☐ Very Satisfied

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I. Spiritual Resources

How significant a role does spirituality play in your life? ☐ None ☐ Somewhat important ☐ Significant ☐ Very Significant

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J. Other

Is there anything else you think I should know about prior to our beginning your treatment? _____

_____

_____

_____