

**Client Information Form**

Today's date: \_\_\_\_\_

Note: If you have been a patient here before, please fill in only the information that has changed.

**A. Identification**

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Age: \_\_\_\_\_

Your nicknames or aliases: \_\_\_\_\_

Home street address \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home/evening phone: \_\_\_\_\_ Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

Cellular Phone/Pager: \_\_\_\_\_

**B. Referral: Who gave you my name to call?**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**C. Chief concern**

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**D. Treatment**

1. Have you ever received psychological or psychiatric or counseling services before?  No

Yes If yes, please indicate:

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

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

If yes, please indicate:

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

**E. Your Medical Care**

From whom or where do you get your medical care?

Clinic/doctor's name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

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

**F. Your current employer**

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Work phone: \_\_\_\_\_

Calls will be discreet, but please indicate any restrictions: \_\_\_\_\_

**G. Marital/relationship history**

Spouse's name    Your age at marriage    Spouse's age at marriage    divorced/widowed?    Is spouse remarried?

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**H. Children (Indicate which are from a previous marriage or relationship with the letter P in the last column)**

Name    Current age    Sex    School    Grade    Adjustment problems?    P?

_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

**I. Other**

Is there anything else that is important for me as your therapist 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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_