

CLIENT INFORMATION

Name: _____ DOB: _____

Address: _____

CITY: _____ ZIP: _____

Home: _____ Cell #: _____

Email: _____

(Please circle your preferred telephone contact number)

Marital Status: _____

Name of Spouse/Partner: _____

Children (Names & Ages): _____

Occupation: _____

Employer: _____

Emergency Contact Name: _____

Emergency Contact Address: _____

Emergency Contact Phone #: _____

Referred By: _____

Why are you seeking therapy
at this time?

Problems in work life?

Problems in relational life?

If therapy is helpful, how will
your life change?

Previous Psychotherapy:

With whom/when:

Psychiatric Hospitalizations:

Date and reason for admit:

Have you ever made a suicide
attempt?

If so, please indicate date and
method used:

Are you currently having
suicidal thoughts?

Yes _____ No _____

Medication (Purpose of each;
for example, anxiety, high
blood pressure, etc.):

PLEASE INDICATE ANY OF THE FOLLOWING THAT CURRENTLY APPLY:

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Digestive Problem | <input type="checkbox"/> Drinking Problem |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Drug Problem | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Poor Concentration |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Injuries/Accidents | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Irritable Bowel | <input type="checkbox"/> Disordered Eating | <input type="checkbox"/> Explosive Anger |
| <input type="checkbox"/> Disordered Sleep | <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Sexual Problems | <input type="checkbox"/> Restless Leg Syndrome | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Impulsivity | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Decreased Energy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Significant Weight Change |

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Other
Symptoms:

Other
Comments:

I have completed this client information form truthfully and to the best of my abilities.

Name (Print): _____ Date: _____

Signature: _____

Guardian (Adolescent/Dependent)

Name (Print): _____ Date: _____

Signature: _____

As Witnessed By Therapist:

Name (Print): _____ Date: _____

Signature: _____