Client Information Form

Please provide the following information to the best of your ability prior to our first meeting. If you are not comfortable answering a particular question, simply skip it. If the question does not apply to you, please indicate, N/A.
We will discuss your responses together when we meet and you will have the opportunity to ask questions or clarify anything you would like to explain further.
Note: If you have been a client here before, please fill in only the information that has changed.

Today's date: ___________________

Identification and Contact Information

Your legal name: ____ Date of birth: __________________ Age: ____

Preferred Name/Nickname: __________________________ Gender: _______________________

Home street address: ____ Apt.: ______________

City: _____________________________________ State: _____ Zip: ____________

Cell phone number: _________________________ Do I have permission to text you on this phone? ☐Yes ☐No

Alternate phone number: ____________________________ Can I leave brief messages at this phone #? ☐Yes ☐No

e-mail address: _____________________________________

Calls or e-mail will be discreet, but please indicate any restrictions: ____

Referral:

How did you hear about my practice/who referred you? ____

Personal Identity and Community

Religious denomination/affiliation: ____________________________________

Involvement: ❑ None ❑ Some/irregular ❑ Active

Please share any community you are meaningfully involved with here: _______________________________________

Ethnicity/national origin: ______________________________ Race: _________________________

Any other way you identify yourself and consider important: ____

Are you experiencing any concerns or problems related to your personal identity or community belonging? ☐Yes ☐No

Please explain: ____

Emergency contacts

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

Name: __________________________________ Phone: ____________________ Relationship: ________________

Name: __________________________________ Phone: ____________________ Relationship: ________________

Chief concern

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

____

____

____

Education and vocational training

Highest level of education completed and/or degree: ____

Do you have any history of a learning disabilities or special education? ☐Yes ☐No

Please explain: ____

List any special vocational training you have received: ____

Are you currently enrolled in an academic or training program? ☐Yes ☐No

Please explain: ____

Are you currently experiencing any school/training problems? ☐Yes ☐No

Please explain: ____

Employment and military experience

Have you ever served in the military? ☐Yes ☐No If so, please list years, branch, rank, and discharge type:

____

Do you have access to VA benefits? ☐Yes ☐No

What type of work do you normally do? ___________________________

What other type of work history do you have? ____

Are you currently employed? ☐Yes ☐No Employer: ____

Job title: ______________________ How many hours per week do you work? ______________

Are you currently experiencing any employment or vocational problems? ☐Yes ☐No

Please explain:____

Are you having any serious financial problems? ☐Yes ☐No

Please explain:____

Are you relying on another person or source for significant financial support? ☐Yes ☐No

Please explain:____

Medical History/Healthcare

Are you currently in a physician's care or do you at least have access to medical care, as needed?

☐Yes ☐No Health care provider's name (optional): ____

Please list any current medical conditions or concerns: ____

____

Have you ever suffered any injury or trauma to your head or brain? ☐Yes ☐No

Please explain: ____

Please explain any other relevant medical history: ____

____

Please list any prescription medications you are currently taking, as well as any over the counter medications or supplements you take regularly: ____

____

____

Do you experience chronic pain that interferes with your life? ☐Yes ☐No

Please explain: ____

Are you experiencing any other unexplained/untreated physical symptoms or concerns? ☐Yes ☐No

Please explain: ____

Family-of-origin history

Who primarily raised you or cared for you during your childhood? ____

How would you describe your upbringing/childhood? ____

Please describe your parents' relationship history? ____

# of siblings: ________ Significant sibling details: ____

Please list any other family members/relatives who have had a major impact in your life (good or bad):

____

Are you experiencing any problems with members of your family of origin at this time? ☐Yes ☐No

If so, please explain: ____

Significant/Romantic relationship history

Sexual orientation: ___________________________ Current relationship status: _________________________________

Have you ever been married or partnered romantically? ☐Yes ☐No Please briefly explain any significant relationship history: ____

____

Name of your current spouse/significant other: ____________________________

Are you experiencing any serious relationship problems at this time? ☐Yes ☐No

Please explain: ____

Social Support

Please identify any other close friends, advocates, helpers, etc., who are a part of your social support system:

____

Are you experiencing any social problems at this time? ☐Yes ☐No

Please explain: ____

Children/Parenting

Name	Age	Gender	In your custody?	Other relevant information about child?
			Yes / No / Joint	
			Yes / No / Joint	
			Yes / No / Joint	
			Yes / No / Joint	
			Yes / No / Joint	

Are you experiencing any problems with your children or having any concerns about them? ☐Yes ☐No

Please explain: ____

Have you ever had any involvement with the Dept. of Family Services or Child Protective Services? ☐Yes ☐No

Please explain: ____

Legal History

Are you presently involved in any civil or criminal legal matters? ☐Yes ☐No

Please explain: ____

Do you have any history of involvement in the criminal justice system? ☐Yes ☐No

Please explain: ____

Substance Use History

Please indicate how often you use the following substances: (circle one for each)

Caffeine	never	a few times a year	a few times a month	a few times a week	daily
Nicotine/Tobacco	never	a few times a year	a few times a month	a few times a week	daily
Alcohol	never	a few times a year	a few times a month	a few times a week	daily
Marijuana/THC	never	a few times a year	a few times a month	a few times a week	daily
Other drugs	never	a few times a year	a few times a month	a few times a week	daily

Have you ever received treatment for a substance use problem? ☐Yes ☐No

Please explain: ____

From your perspective have you ever misused, abused, or been addicted to any substance? ☐Yes ☐No

Please explain: ____

Are you experiencing any problems related to substance use at this time? ☐Yes ☐No

Please explain: ____

Behavioral/Mental Health Treatment

Have you ever received psychological, psychiatric, or psychotherapy services before? ☐Yes ☐No

If yes, please indicate when, from whom, and for what: ________________________________

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Have you ever taken medications for psychiatric or behavioral problems? ☐Yes ☐No

If yes, please indicate what medications, when, and for what: __________________________

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Are you seeking counseling with the goal or being evaluated/screened for a problem (i.e. wondering if you have a drug problem) or in an attempt to prevent a problem (i.e. premarital counseling)? ☐Yes ☐No

Please explain: ____

Abuse/Trauma History

Please summarize any experiences you have had that you consider to have been traumatic: ______________

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Please check all that apply:

❑ I have never been abused in any way. ❑ I was abused in the past. ❑ I am currently being abused.

Types of abuse/mistreatment I have experienced:

❑Physical, such as being punched, beaten, choked, pushed, slapped, etc.

❑Sexual, such as being molested, touched inappropriately, or raped, etc.

❑Neglect, such as having a parent/guardian fail to feed, shelter, nurture or protect.

❑Emotional, such as being humiliated, repeatedly put down/degraded, etc.

❑Bullying, discrimination, oppression.

Are you experiencing concerns about your safety now? ☐Yes ☐No If yes, please explain:

____

Behavioral/Emotional Concerns

Please check if you have ever experienced concerns about the following and indicate if this was a concern in the past, recently, or both.

Concerns about:	In past X	Recently X	Concerns about:	In past X	Recently X
Relationship issues			Hallucinations		
Parenting			Paranoid thoughts		
Family problems/transitions			Anger		
Problems with socializing			Violent behavior		
Conflict resolution			Homicidal thoughts		
Sexuality or sexual behavior			Criminal thoughts/behaviors		
Communication problems			Difficulty concentrating		
Changes or transitions in your life			Impulsivity		
Children’s behavior problems			Irritability		
Lack of motivation			Combat related stress		
Loneliness			Response to trauma		
Depression			Anxiety or tension		
Hopelessness			Obsessive thinking		
Grief or loss			Compulsive behavior		
Suicidal thoughts or behavior			Panic attacks		
Self harm behaviors			Significant or persistent fear		
Sleeping problems			Internet use or gaming		
Appetite problems			Gambling behavior		
Energy problems			Money or spending		
Memory problems			Eating habits		
Difficulty coping with physical pain			Body image		
Managing stress			Self esteem		
Unresolved issues of your past			Time management		
Organization or lifestyle balance					

Have you ever seriously considered suicide? ☐Yes ☐No

Please explain: ____

Have you ever attempted suicide? ☐Yes ☐No

Please explain: ____

Please indicate if there is any other information you would like me to know about you at this time.

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This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.