Client Information Form

Today's date: ___________________________

Identification

Your full name: ________________________________ Date of birth: ____________________ Age: _______

Maiden name or previous names: _________________ Nickname, if any: ____________ How do you prefer to be addressed? ________________________

Marital Status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Remarried ☐ Widowed ☐ Other:_______

Spouse's name (if applicable) ____________________ Date of Marriage ____________

Home street address: ____ Apt.: _____

City: ____ State: _________________ Zip: __________________

Living situation: ☐ Alone ☐ With others (Identify with whom: Spouse Children Parents Partner Friend/s Other)

Home/evening phone: ________________ Cell phone: __________________ Calls will be discreet, but please Indicate any restrictions or the best way to contact you: ____
e-mail address: _________________________

Current employment

Currently employed: ☐ No ☐ Yes If yes, your title or position: ____________________________________

Number of years at current job: ___ Employer: ____

Employment Address: ____

Normal days/hours worked: Mon______ Tue______ Wed______ Thu______ Fri______ Sat______ Sun_____

Work phone: _________________ Calls will be discreet, but please indicate any restrictions: ________________

Spouse's occupation (if applicable) ____________________________________

Emergency Information

If some kind of emergency arises and you cannot be reached directly, whom should be called or contacted?

Name: ____ Phone: ___________________________________
Address: ____
Relationship: ____

How did you learn about me? ☐ Prior knowledge ☐ Internet search ☐ Church ☐ Referral

If by referral, may I have your permission to thank this person for the referral? ☐ Yes ☐ No

Name: ____ Phone: ___________________________________
Address: ____

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

[*Note: This is a strictly confidential patient medical record, for which redisclosure or transfer is prohibited by law.*]

Chief concern or reason for seeking counseling services:

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

Prior 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?

Medical care: From whom or where do you (or the client, if other than yourself) obtain medical care?

Clinic/doctor's name: ____ Phone: ________________________

Address: ____

If entering 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

Religious and racial/ethnic identification

Religious denomination/affiliation**:** ____

Are you actively practicing ☐ or non-practicing ☐ at this time? (Check one)

Which, if any, church, synagogue, or meeting place do you attend? _____________________________________

Are religious or spiritual issues important in your life? ☐ Yes ☐ No Explain:_________________________

____

Ethnicity/national origin: ______________________________

Race: ☐ White ☐ Black ☐ Hispanic ☐ Other: ____________________________

Marital/relationship history

	Spouse's name	Spouse's age at marriage	Your age at marriage	Your age when divorced/widowed	Is spouse remarried?
Current	______________________	________	_________		
Previous (if applicable)	_____________________	________	_________	____________	____________
	_______________________	________	__________	_____________	_____________

Significant nonmarital relationships

	Name of person	Person's age when started	Your age when started	Your age when ended	Reasons for ending
First	___________________________	______	_______	________	________________________
Second	_________________________	_____	_______	________	________________________
Third	___________________________	______	_______	________	________________________

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

Name	Sex	Age	Birth date	School	Grade	P?
_________________________	____	____	____________	_________________________	____	__
_________________________	____	____	____________	_________________________	____	__
_________________________	____	____	____________	_________________________	____	__
_________________________	____	____	____________	_________________________	____	__
_________________________	____	____	____________	_________________________	____	__
_________________________	____	____	____________	_________________________	____	__

(Please note below if there are any significant problems in your relationships within your immediate family or if any other members of your family are experiencing difficulties; e.g. children having academic or behavioral problems.)

Family-of-origin history

Relative	Name	Current age (or age at death)	Illness (or cause of death, if deceased)	Education	Occupation
Father					
Mother					
Step-parents					
Grandparents					
Brothers					
Sisters					

Relationships in your family of origin. Please describe the following:

1. Your parents' relationship with each other: ______

2. Your relationship with each parent or with other adults, such as grandparents, still present in your family: ______

3. Your parents' physical health problems, chemical use, and mental or emotional difficulties: ______

4. Your relationship with your brothers and sisters, in the past and present: ______

Abuse history: I was not abused in any way. I was abused. If you were abused, please indicate the following. For kind of abuse, use these letters: P = Physical, such as beatings. S = Sexual, such as touching/molesting, fondling, or intercourse. N = Neglect, such as failure to feed, shelter, or protect you. E = Emotional, such as humiliation, etc.

Your age	Kind of abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

Education and training

Education: Years of school completed: ________ Highest Degree Attained __________
Major Area of Interest _________________________

Schools Attended:

Dates		School & Location	Academic Experience		
From	To		Poor	Average	Good
______	_______	____	____	____	____
______	_______	____	____	____	____
______	_______	____	____	____	____
______	_______	____	____	____	____

(Please note any problems experienced during school years: academically, such as learning disabilities or special education needs; behaviorally; or relationally, such as problems with particular teachers or students, adjustments to new schools, etc.)

Spouses Education (if married): Years of school completed: ________ Highest Degree Attained __________
Major Area of Interest _________________________

Employment and military experiences

Dates				
From	To	Name of military or employers	Job title or duties	Reason for leaving
______	_______	_____________________________	_________________________	_______________
______	_______	_____________________________	_________________________	_______________
______	_______	_____________________________	_________________________	_______________
______	_______	_____________________________	_________________________	_______________

(Be sure to include longest employment experience.)

Please also note for spouse, if married:

Dates				
From	To	Name of military or employers	Job title or duties	Reason for leaving
______	_______	_____________________________	_________________________	_______________
______	_______	_____________________________	_________________________	_______________
______	_______	_____________________________	_________________________	_______________

(Please note any financial needs or difficulties being experienced, noting resources available to you.)

Legal History

Please note if you are having, or have had, any legal problems (including any arrests, charges, or convictions) or are involved in any law suits or other litigations? (Please use back side of page if additional space is needed.)

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

Medical History:

1. Starting with your childhood and proceeding up to the present, list *all* diseases, illnesses, important accidents and injuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had. (Describe pregnancies below.)

Age	Illness/diagnosis	Treatment received	Treated by	Result

For Women Only -- Please list all of your pregnancies, noting what happened with each pregnancy?

	Your age	Miscarriage	Abortion	Child born	Problems?
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

2. Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

3. List *all* medications or drugs you take or have taken in the last year—prescribed, over-the-counter, and others.

Medication/drug	Dose (how much?)	Taken for	Prescribed and supervised by

Health Habits

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

Describe any specific health concerns you have at this time?

Are you considered disabled in any way? ☐ Yes ☐ No If yes, please specify disabilities:

What kinds of physical exercise do you get?

How much coffee, cola, tea, or other sources of caffeine do you consume each day?

Do you drink alcohol in any amount? □ No □ Yes If yes, would you say you are □ a social drinker □ a heavy drinker □ an alcoholic, or □ have a drinking problem? Or how would you describe your use, past or present?

Have you ever felt the need to cut down on your drinking? □ No □ Yes

Have you previously or do you currently abuse prescription medications or use any form of illegal drugs? □ No □ Yes
If yes, would you say you are □ a recreational drug user □ an addict, or □ have a drug problem? Or how would you describe your use, past or present?

Do you smoke or chew tobacco? □ No □ Yes If yes, how much and how often?

Do you try to restrict your eating in any way? How? Why?

How many hours of sleep do you get on an average night? _____

Do you have any problems getting to sleep or waking and not being able to fall asleep again. If so, please describe.

Have you ever experienced panic or panic-like conditions (anxiety attacks)? □ No □ Yes

Are you sexually active at this time? □ No □ Yes

Note age of 1st encounter _____ and number of partners you have had ________.

Are you experiencing any difficulties in this area of your life? □ No □ Yes

Social Interactions/Leisure Activities

To whom do you feel closest?

How many friends do you have in whom you feel you can confide or turn to for support?

Note any supportive groups or activities in which you are involved?

What hobbies or leisure activities do you enjoy?

What activities do you participate in with family or friends?

SYMPTON CHECKLIST

Please check any of the following that apply to you currently or have been a recent concern.

- ☐ Always tired
- ☐ Poor appetite
- ☐ Trouble getting to sleep
- ☐ Waking up during the night
- ☐ Lack of energy
- ☐ Crying spells
- ☐ Unable to have fun
- ☐ Depressed
- ☐ Can't concentrate
- ☐ Can't get going
- ☐ Loss of sexual interest
- ☐ Can't make decisions
- ☐ Lacking in motivation
- ☐ Thoughts of hurting myself
- ☐ Feeling worthless
- ☐ Loss of meaning to life
- ☐ Lacking in confidence
- ☐ Unresolved grief
- ☐ Feelings of guilt
- ☐ Avoid contact with friends
- ☐ Feeling inferior
- ☐ Not enjoying usual activities
- ☐ Feeling easily hurt
- ☐ Tendency to put off doing things
- ☐ Don't feel like being alone
- ☐ Losing weight
- ☐ Sleep whenever I can
- ☐ Frequent thoughts about death
- ☐ Loneliness
- ☐ Troubled by childhood events
- ☐ Nightmares
- ☐ Reliving past events
- ☐ Feeling fearful
- ☐ Quick to startle
- ☐ Unable to relax
- ☐ Feeling irritable or on edge
- ☐ Angry outbursts
- ☐ Restless, tense
- ☐ Fast heartbeat
- ☐ Feeling panicky
- ☐ Frequent sweating
- ☐ Shaky hands
- ☐ Dizzy, lightheaded
- ☐ Nausea, stomach problems
- ☐ Trouble swallowing
- ☐ Numbness or tingling
- ☐ Chills or hot flashes
- ☐ Constipation
- ☐ Frequent diarrhea
- ☐ Always worried
- ☐ Obsessive thoughts or fears
- ☐ Compulsive behaviors
- ☐ Shy with people
- ☐ Muscles twitching
- ☐ Fainting spells
- ☐ Frequent headaches
- ☐ Poor circulation
- ☐ Worried about health
- ☐ Sexual problems
- ☐ Avoiding crowds
- ☐ Racing thoughts
- ☐ Frequently daydreaming
- ☐ Hear voices or have difficulty telling what's real
- ☐ Impatient with people
- ☐ Feeling angry
- ☐ Quick tempered
- ☐ Feel like hurting someone
- ☐ Feel like smashing things
- ☐ Can't make friends
- ☐ Excessive spending of money
- ☐ Difficulties at work
- ☐ Difficulties with school (past or present)
- ☐ Full of energy
- ☐ Financial problems
- ☐ Unable to keep a job
- ☐ Excessive drinking
- ☐ Use of pornography
- ☐ Marital problems
- ☐ Excessive use of drugs
- ☐ Problems with children
- ☐ Problems with parents
- ☐ Problems responding to others in authority
- ☐ Excessive use of medication
- ☐ Recent loss of someone close to you
- ☐ Unable to pray
- ☐ Unable to forgive
- ☐ Unable to feel forgiven
- ☐ Feel distant from God
- ☐ Confused about God
- ☐ Angry at God

Is there anything else that is important for me as your therapist to know? (Please use additional sheet if needed.)

Completed by: ____________________________________ (Client Signature) Date _____________