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Confidential Client Information

Please provide the following information for our records. Leave blank any question you would rather not answer. Information you provide here is held to the same standards of confidentiality as your therapy.

Please print out this form and bring it to your first session or allow yourself 30 minutes prior to your appointment to complete the form in the office.

Name: _____
(First) (Last)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Name: _____
(First) (Last)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Names and ages of Children: _____

_____

_____

Home Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: _____ Messages okay? □Yes □No

Cell/Other Phone: _____ Messages okay? □Yes □No Text okay? □Yes □No

E-mail: _____

May we email you? □Yes □No
*Please be aware that email might not be confidential.

Emergency contact name: _____

Emergency contact phone number: _____

About once a year, I like to follow up with all of my clients who have ended counseling by sending them a short questionnaire on the effectiveness of their therapy experience. Could I mail this to the above home address? □ Yes □ No

How did you learn of my counseling services? _____

Whom may I thank for referring you? _____

Are you **currently** receiving psychiatric services, professional counseling or psychotherapy elsewhere?
□No
□Yes, at current counselor's name: _____

Have you received **previous** psychiatric services, professional counseling or psychotherapy?
□No
□Yes, at previous counselor's name: _____

What was helpful/unhelpful about this experience? _____

_____

Are you currently taking prescribed psychiatric medication (e.g. antidepressants, antianxiety, sleep medication, Antabuse, etc)?
□No
□Yes
If yes, please list: _____

If no, have you been previously prescribed psychiatric medication?
□No
□Yes
If Yes, please list: _____

Have you ever been hospitalized for any reason? If yes, please explain and give dates:

_____

_____

HEALTH AND SOCIAL INFORMATION

1. How is your physical health at present? (please circle)
Poor Unsatisfactory Satisfactory Good Very good

2. Please list any persistent physical symptoms or health concerns (e.g. chronic pain, headaches, hypertension, diabetes, etc.) and list any medication you are taking for this condition:

_____

_____

3. Are you having any problems with your sleep habits? □ No □ Yes

If yes, check where applicable:
□ Sleeping too little □ Sleeping too much □ Poor quality sleep
□ Disturbing dreams □ Other _____

4. How many times per week do you exercise? _____
What form of exercise? _____
Approximately how long each time? _____

5. Are you having any difficulty with appetite or eating habits? □ No □ Yes
If yes, check where applicable:
□ Eating less □ Eating more □ Binging □ Restricting

Have you experienced significant weight change in the last 3 months? □ No □ Yes

6. Do you regularly use alcohol? □ No □ Yes
In a typical month, how often do you have 4 or more drinks in a 24-hour period?

_____

7. Do you regularly smoke tobacco? □ No □ Yes If yes, how much? _____

8. How often do you engage in recreational drug use? □ Daily □ Weekly □ Monthly
□ Rarely □ Never

9. If you are married or in a relationship, how would you rate the quality of your current relationship on a scale of 1-10? _____

10. In the last year, have you experienced any significant life changes or stressors? Please list:

_____

_____

_____

_____

Please check any of the following that you are currently experiencing:

___ Depression/Sadness
___ Sleep Disturbance
___ Anger/Irritability
___ Domestic Violence
___ Relationship Conflicts
___ Workplace Stress
___ Communication/Trust Problems
___ Chronic Medical Problems
___ Binging/Purging/Anorexia
___ Hallucinations
___ Unexplained Losses of Time
___ Unexplained Memory Lapses
___ Isolation/Withdrawal
___ Homicidal Thoughts
___ Impulse Control Difficulty
___ Difficulty Expressing Feelings
___ Victim of Abuse
___ Perpetrator of Abuse
___ Grief/Loss
___ Problems Thinking/Concentrating
___ Addictive Behavior of any kind
___ Alcohol/Substance Abuse
___ Sexual/Intimacy Issues
___ Aggression/Violence
___ Suicidal Thoughts
___ Self-Harm/Injury, Cutting
___ Anxiety, Panic, Worry, Phobia
___ Obsession and/or Compulsions
___ Low Self-Esteem/Confidence
___ Pronounced Mood Swing
___ Stress/Feeling Overwhelmed
___ Legal/Financial Problems
___ Religious/Spiritual Issues
___ Issues of Sexuality /Gender
___ Traumatic Brain Injury
___ Parenting Issues

EDUCATION AND OCCUPATIONAL INFORMATION:

Please list highest level of education: _____

Are you currently employed? □ No □ Yes
If yes, who is your current employer/position? _____

If yes, are you happy at your current position? _____

Please list any work-related stressors, if any: _____

SPIRITUAL INFORMATION:

Is your faith an important part of your life? □ Yes □ No
If yes, what is your faith? _____

Would you like to include your faith in the therapeutic process? □ Yes □ No

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following?
(Circle any that apply and list family members)

Difficulty	**Family Member (e.g. mom, brother)**
Depression	yes/no _____
Bipolar Disorder	yes/no _____
Anxiety Disorders	yes/no _____
Panic Attacks	yes/no _____
Schizophrenia	yes/no _____
Alcohol/Substance Abuse	yes/no _____
Eating Disorders	yes/no _____
Learning Disabilities	yes/no _____
Trauma History	yes/no _____
Suicide Attempts	yes/no _____

What concerns bring you in? What are your goals for therapy? (Please be specific).

What are your reservations about therapy?

Do you have thought or preferences about how you would like therapy to proceed?