CLIENT INFORMATION SHEET

TODAY'S DATE_____ NAME_____ DATE OF BIRTH_____

HOME ADDRESS _____
Street City, State Zip

RELATIONSHIP STATUS: ___ single ___married____ engaged ___ divorced ___ separated ___widowed__ living with partner ___partnered but not living with partner___ priest/religious

CHILDREN (names, ages and where they are living. Please indicate if children are biological or adopted)_____
_____

NAMES AND AGES OF THOSE LIVING IN YOUR HOUSEHOLD (please include pets):
_____
_____

LEVEL OF EDUCATION: ___high school __associates degree __university/college __graduate degree

WORK STATUS: ___work in home as parent, homemaker, caretaker ____work outside of home ___work from home ___ self-employed __unemployed ___ retired

CURRENT EMPLOYER:_____ **JOB TITLE/POSITION:**_____

MILITARY HISTORY: (branch of service, where you served and dates)
_____
_____

FAITH OR RELIGIOUS IDENTITY:
Did you grow up in a faith/religious tradition ___yes ___no
If yes, which one(s): _____
Do you currently identify with a faith or religious community? ___yes ___no
If yes, which one(s)? _____

WHAT IS YOUR GENDER IDENTITY: ___female ___male ___transgender ___non-binary ___other

HOME PHONE#_____ **(ok to leave a message __yes ___no)**

WORK PHONE #_____**(ok to leave a message ___yes ___no)**

CELL PHONE #_____**(ok to leave a message ___yes ___no)**
(Please circle the # you prefer me to call and/or leave a message)

Email (for sending insurance-ready statements**)**_____

EMERGENCY CONTACT PERSON AND PHONE NUMBER_____
What is your relationship with this person?_____

REFERRED BY_____
(May I contact this person to thank them for referring you? ____ Yes ____ No

HAVE YOU BEEN IN THERAPY BEFORE? ____Yes ___No. If yes, please give the dates of therapy, the reason you sought therapy, and whether the therapy was a beneficial experience or not.
_____
_____

HAVE YOU EVER BEEN TREATED FOR AN ADDICTION, EATING DISORDER, OR ANY OTHER COMPULSIVE BEHAVIORS? ___Yes ___No. If yes, please give specific type of compulsive behavior, dates of treatment, and outcome of treatment.

_____
_____

ARE YOU CURRENTLY ACTIVE IN ANY ADDICTION OR COMPULSIVE BEHAVIOR? ___Yes ___No
If yes, please state the addiction or compulsive behavior(s)_____
_____

DO YOU HAVE ANY MAJOR OR CHRONIC HEALTH PROBLEMS? ___Yes ___No
If yes, please explain briefly and give current status of this problem and how it impacts your daily life, relationships, functioning.

_____
_____

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION MEDICATION? ___Yes ___No
If yes, list medications and dosage:_____
_____

ARE YOU UNDER THE CARE OF A PSYCHIATRIST? Yes __ No__ If yes, what is psychiatrist's name and phone #: _____

ARE YOU NOW OR HAVE YOU BEEN INVOLVED IN ANY LEGAL DISPUTES?
___Yes ____No. If yes, please state if legal disputes are currently ongoing and whether these legal disputes are personal or business related._____
_____

ARE YOU OR HAVE YOU BEEN INVOLVED IN ANY VIOLENT BEHAVIOR TOWARD OTHERS OR YOURSELF? ____Yes ____No. If yes, please explain and give dates of these behaviors._____

HAVE YOU EVER BEEN SUICIDAL OR ATTEMPTED SUICDE? __Yes __ No. If yes, give date(s) and details _____

ARE YOU CURRENTLY HAVING SUICIDAL THOUGHTS OR BEHAVIORS? ___Yes ___No. If yes, give details _____
_____

DO YOU FEEL EMOTIONALLY AND PHYSICALLY SAFE IN YOUR LIVING SITUATION? __yes __ no
WHAT CONCERNS BRING YOU HERE?_____
_____
_____
_____

WHAT ARE YOUR GOALS IN THIS THERAPY? _____
_____
_____