

CLIENT INFORMATION SHEET

TODAY'S DATE _____ NAME _____ DATE OF BIRTH _____

HOME ADDRESS _____
Street City, State Zip

MARITAL STATUS: married _____ engaged _____ single, never married _____ divorced _____ separated _____
widowed _____ living with partner _____ partnered but not living with partner _____ priest/religious _____

CHILDREN (names, ages and where they are living) _____

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

PLACE OF EMPLOYMENT/OCCUPATION _____

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

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 SUICIDE? ___Yes ___ No. If yes, give date(s) and details _____

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

WHAT CONCERNS BRING YOU HERE? _____

WHAT ARE YOUR GOALS IN THIS THERAPY? _____
