CLIENT INFORMATION SHEET

TODAY'S DATE_____ NAME_____ DATE OF BIRTH_____

HOME ADDRESS _____
Street City, State Zip

RELATIONSHIP STATUS: ___ single____ divorced ____married _____separated ____widowed _____engaged____ 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):

_____

_____

WORK STATUS: ____work within home as parent, homemaker, caregiver ___work outside of home ___ work from home ____unemployed ____ retired

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 CULTURAL OR ETHNIC BACKGROUND? _____

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

_____

HOW DO YOU IDENTIFY REGARDING GENDER? ___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 PHYSICALLY AND EMOTIONALLY SAFE IN YOUR LIVING SITUATION? _____Yes ____No. If no, please explain _____
_____

WHAT CONCERNS BRING YOU HERE?_____
_____
_____

WHAT ARE YOUR GOALS IN THIS THERAPY? _____
_____
_____