# CLIENT INFORMATION FORM

This form collects contact and demographic information as well as general medical and mental health information, if there are any questions regarding medical or mental health information that are not relevant or you do not feel comfortable addressing in detail on this form, please leave them blank and discuss them with your counselor. The more information you can give us the quicker we can get you the help you are looking for.

____New client ____Returning client

**Name:** _____
*First* *M.I.* *Last*

Name you would like to be addressed by: _____

**Date of Birth:** _____ **Age:** _____ **Gender:** _____

**Address:** _____
*Street* *Apt #*

_____
*City* *State* *Zip Code*

Is it ok to send mail to this address? _____yes _____no

If you marked no, please provide an alternative address that we may use for billing purposes, if necessary: _____
*Street* *Apt #*

_____
*City* *State* *Zip Code*

**Best Phone #**: _____ Best **E-mail**: _____

**Ethnicity**: _____

**Current Living Situation:**

Marital Status: Single_____ Married_____ Divorced_____ Separated____ Other____

Composition of Present Household (check all that apply):

Alone____ With Parent(s)/Guardian(s)_____ With Spouse_____ With Partner___
With Roommate(s)_____ Other(describe):

_____

Number of Children: _____ Ages:

_____

Number of Children in Household: _____ Number of Children Living_____

Are you or your significant other currently pregnant? _____yes _____no

Are you our your significant other trying to get pregnant? _____yes _____no

Any issues relating to infertility? _____yes _____no

**Family**:

Is your mother living? _____yes _____no If yes, Mother's Age: _____

If no, your age at Mother's death: _____ Your Mother's Age at Death: _____

Is your Father living? _____yes _____no If yes, Father's Age: _____

If no, your age at Father's death: _____ Your Father's Age at Death: _____

Number of Brothers: _____ Number of Sisters: _____

Are your siblings living? _____yes _____no If no, your age at sibling's death_____

Your Position in the Family:

Eldest: _____ Middle_____ Youngest_____
Twin_____ Only Child_____

Were you adopted? _____yes _____no If yes, at what age? _____

**Education:**

Your highest education level attained (please check one):

Elementary School_____ Middle School_____ High School_____
Some College_____ College Graduate_____ Trade School_____
Master's Degree_____ Doctorate, J.D. or MD_____

Are you currently in school? _____yes _____no If yes, what grade/level? _____

**Employment:**

Occupation: _____

Full Time_____ Part Time_____ Self Employed_____
Student_____ Unemployed_____ Homemaker_____

Are you a veteran? _____yes _____no
Are you currently serving in the military? _____yes _____no If yes, which branch?
Average number of hours worked each week? _____

**Financial:** Current Income: _____
Are financial issues causing you problems? _____yes _____no
If yes, please explain: _____

**Medical:**

Personal Physician: _____
Address: _____
Phone: _____

If you would like your counselor to collaborate with your physician, please complete a Consent for Release of Information Form.

Date of Last Physical: _____
Medical Conditions (past or present):

_____
_____
_____
_____

Are you currently taking any medications: _____yes _____no?
If so, please list the type and dosage:

_____
_____

**Health and Wellness:**

Please rate your overall health: ___Optimal ____Good ___Average _____Poor

Please indicate if you have concerns in any of the following areas related to your health/wellness:

Sleeping_____yes _____no  Eating (Appetite)_____yes _____no
Weight (Gain or Loss) _____yes _____no  Exercise_____yes _____no

If you consume/use any of the following, please indicate how often/much in a day/week:

Caffeine_____  Alcohol_____
Tobacco_____  Marijuana_____
Other_____

What activities, if any, do you engage in for relaxation/leisure: _____

Please rate your support system: ___Optimal ____Good ___Average _____Poor
Please explain your support system (What do you find supportive? Are you lacking support?)

_____
_____

List the relationships that support your wellbeing: _____
_____

**Spirituality/Religion:**

Are you affiliated with any Religion or Spirituality? _____yes _____no
How important are religious/spiritual matters to you? _____Not Important _____Little _____Moderate _____Very

**Mental Health:**

Previous mental health or emotional issues: _____
_____
_____
_____
_____

Have you been to therapy in the past? _____yes _____no
If yes, when?

_____
If yes, what brought you to therapy at that time?

_____
Have you been diagnosed with a mental health disorder (past/current): _____yes _____no
If yes, please specify: _____

Is there any history of mental health disorders in your family? _____yes _____no
If yes, please explain: _____
_____
Any special, unusual or traumatic circumstances that affected your development? ___yes ___no

If yes, please explain: _____
_____
Have you ever been the victim of emotional, verbal, physical, or sexual abuse/assault?

___yes ___no
If yes, please explain: _____
_____
What is your sexual orientation?
____Heterosexual ____Gay ____Lesbian ____Bisexual
____Transgendered ____Transsexual ____Questioning ____Other: _____
Do you have any concerns with your sexuality? _____yes _____no
Have you ever attempted suicide? _____yes _____no
Have you recently considered committing suicide? _____yes _____no
Are you currently considering committing suicide? _____yes _____no
Has a family member ever committed suicide? _____yes _____no
Have you engaged in self-injurious behavior? _____yes _____no
Have you ever been admitted to the Hospital for psychiatric care? _____yes _____no
If yes, please explain: _____
_____
Have you ever been in an inpatient treatment program? _____yes _____no
Have you ever been charged with a felony offense or a crime of a sexual or violent nature?
_____yes _____no
Have you ever been diagnosed with and/or been in treatment for a substance abuse disorder?
_____yes _____no
If yes, please explain: _____
_____

Have you ever been diagnosed with and/or been in treatment for an eating disorder? ____yes
____no
Are you concerned with your current eating habits? _____yes _____no
If yes, please explain: _____
_____
Are you currently seeing a psychiatrist? _____yes _____no
If yes, please provide:
Name: _____ Phone #_____
*It is common for your counselor and psychiatrist to collaborate/coordinate care. If you consent to this collaboration, please complete a Consent for Release of Information form.

**Reason(s) for seeking therapy at this time:** _____
_____
_____
_____

**Outcome(s) you would like to see as a result of therapy**: _____
_____
_____

**Emergency Contact Information:**
**Name: _____ Phone:**
**_____**

Relationship to you: _____
Address: _____
_____

**Referral:**
How did you hear about us? _____
Referral name: _____
Did you come here voluntarily? _____yes _____no

***I certify that all information provided by me is true, accurate, and complete to the best of my knowledge and belief.***

***Client Signature: _____***
***Date: _____***
***Parent Guardian Signature (minor)_____***
***Date: _____***